Health & Lifestyle Assessment

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|  | Questions | Answers |
| Body Measurements |  |  |
| Height (cm) |  |
| Weight (kg) |  |
| Waist Circumference (cm) |  |
| Body Mass Index (BMI) |  |
| Blood Pressure |  |
| Heart Rate |  |
| Medical Conditions | Have you had any medical conditions in the past? | |  |  | | --- | --- | | Medical Condition | Age of Onset | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |
| Past Illnesses | What illnesses have significantly impacted you in the past | |  |  | | --- | --- | | Past Illnesses | Year | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |
| Surgeries | Please list any surgeries you have had in the past | |  |  |  | | --- | --- | --- | | Surgery | Surgeon | Year | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |
| Medications | What medications do you take? | |  |  |  | | --- | --- | --- | | Medication | Drug Class | Reasons Taken | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |
| What medications have you taken in the past? | |  |  | | --- | --- | | Medication | Reason Stopped | |  |  | |  |  | |  |  | |
| Family History | What conditions have impacted members of your family | |  |  | | --- | --- | | Family Relation | Illnesses | | Mother |  | | Father |  | | Siblings |  | | Grandparents |  | | Other |  | |
| Diet & Nutrition | What typical meals would you eat on a standard weekday? (Meal and Portion) | |  |  |  | | --- | --- | --- | | Breakfast | Lunch | Dinner | |  |  |  | |
| Do you tend to have big or small meal portions? |  |
| Do you have any dietary restrictions? |  |
| Do you prefer to eat any types of foods? |  |
| Physical Activity | What physical activities do you perform throughout a week? |  |
| How much exercise would do a week? |  |
| What sports do you play? |  |
| What are your fitness goals? |  |
| Sleep Patterns |  |  |
| How much sleep do you get on a typical night? |  |
| What quality of sleep do you get throughout the night? |  |
| Stress Management |  |  |
| How well do you manage stress? |  |
| How well do you cope with challenging situations? |  |
| Substance Use | How much alcohol would you consume a week? |  |
| How many cigarettes do you smoke a day? |  |
| Do you take recreational drugs? |  |
| Mental & Emotional Wellbeing | Do you have any diagnosed psychiatric conditions? |  |
| To you what are the signs you are anxious? |  |
| Do you get depressed? What does this look like for you? |  |
| Do you have a family history of any other mental health conditions? |  |
| Hydration | How many glasses of water do you drink a day |  |
| Health Goals | What are your health goals and aspirations? |  |
| Social Support | How would you define your family situation? |  |
| Do you have stable relationships? |  |
| Do you have stable friendships? |  |
| Environmental Factors | Where do you currently live? |  |
| How would you explain your living conditions? |  |
| Are is your current employment status? What is your current occupation? |  |
| Habits | How would you describe your current status of personal hygiene? |  |
| How would you describe the current status of your oral health |  |
| What lifestyle habits would you describe as important |  |