The Center for Optimal Health

Follow Up Health Questionnaire

Name: _____ **Appointment Date**: _____

Please list your concerns and questions, in the order of priority:

1. _____
2. _____
3. _____
4. _____
5. _____

Updates in your medical history (any new diagnoses, testing, surgeries/procedures, hospital visits)?

_____
_____

Updates in your family history (any new medical problems in your family members)?

_____
_____

Nutrition/Lifestyle

What do you usually eat throughout a typical day? Please list timing and types of food consumed:

_____
_____
_____
_____
_____

How much time do you take for your meals? Breakfast _____ Lunch _____ Dinner_____
What percentage of your food is:

Leftovers ____ Frozen/packaged foods ____ Raw food ___ Cold foods ___ Red meat ____

Root vegetables (eg. potatoes, yams, beets) ____ Very spicy ___ Very Sour___ Very salty ____

How often do you eat out in a restaurant / have fast food? _____
Do you microwave your food or drinks? _____
Are there any foods that you are intolerant to? Please list: _____
About what percentage of your food is organically grown? _____
What kind of water (and what temperature) do you drink? _____
How much water do you drink a day? _____
How many soda and / or diet sodas do you drink each week? _____
What other beverages (and how much) do you drink?

Juice___ Coffee ___ Tea___ Milk___ Yogurt / kefir drinks ___ Energy drinks ___ Sports drinks___

How is your appetite? _____ How is your energy during the day?_____
Do you feel heavy or sleepy after eating? _____ How do you feel if you skip a meal? _____

How often do you have bowel movements? _____ Are they easy without strain? _____
What is the stool consistency? (circle all that apply): hard / firm / soft / loose /watery / bloody /mucous
Do bowel movements occur about the same time each day? ____ At what time(s)? _____
Do you regularly take laxatives or enemas? _____

How often and at what time(s) of day do you exercise? _____
What types of exercise do you do? _____

_____

How many hours of sleep do you get a night? ____
What time do you go to bed? _____ What time do you get out of bed? _____
Do you have problems falling asleep or staying asleep? Yes / No; If yes, please describe: **_____**
_____
Do you watch TV or use the computer within 1-2 hours of bedtime? _____
Is your cell phone on during the night? ____ Where do you place your cell phone at night? _____
Is there a TV in your bedroom? ____ Any computers or other electronics in your bedroom? _____
Do you feel rested after sleeping? Yes / No **Do you snore?** Yes / No
Do you take naps during the day? if yes, describe: _____

Stress / Environment

How would you rate your stress level? None / Low / Moderate / High / Extremely High
What are the sources of your stress?_____
How do you react to stressful situations (eg. anger, anxiety, etc)**?**
_____
Do you practice meditation or other relaxation techniques? (please list types and frequency):
_____
Do you feel you take enough time for yourself?_____

How many hours per day do you use a computer? ____ How many minutes on a cell phone? _____

How many hours of TV do you watch per week? ____

What do you do for fun? _____

Please describe your social support network: _____
_____

Name: _____ Appointment Date: _____

What medications are you taking? (Please include any over-the-counter-drugs you use.)

Medicine	Dosage	Medicine	Dosage

List all vitamins, minerals, herbs and other nutritional supplements. When possible, indicate the dosage and the form (e.g. calcium carbonate vs. calcium citrate). <u>You may bring in a copy of container labels.</u>

Supplement	Dosage	Supplement	Dosage