

Patient's Name:

Date:

Healthy Habits Questionnaire

In our office, we like talking about healthy lifestyles with all of our patients. Please take a moment to answer the question below. We will review the answers during your visit.

Medical/ Family History

Have you or your family ever had any of the conditions below? (Please circle all that apply)

Diabetes Heart Disease High Blood Pressure Overweight/Obesity Stroke

Healthy Habits

Please check **yes** or **no** for the following statements:

Yes No

I take part in at least 30 mins of physical activity a day, most days of the week.

___ ___

I limit television/screen/media time to no more than 2 hours a day.

___ ___

I get at least 7 to 8 hours of sleep a night.

___ ___

I smoke.

___ ___

I drink more than 36 oz. a week of sugar beverages (juice, soft drinks, sports drinks, iced teas).

___ ___

I eat whole foods or whole grains (nuts, beans, fish, and lean poultry) daily.

___ ___

I eat red meat and or processed meats daily.

___ ___

I have at least 5 servings of vegetables **and** fruits each day.

___ ___

I do not eat while distracted (while watching TV, reading, texting, etc.)

___ ___

Based on your answers, is there **ONE** thing you are willing to change now?

Eat more fruits & vegetables.

Be more physically active.

Spend less time sitting/watching TV.

Eat less fast/processed food.

Drink less soda, juice, sports drinks.

Quit smoking