



LIFESTYLE EVALUATION

Please Print Carefully (*press down*)

WHITE: File copy
YELLOW: Participant's copy
PINK: Personal Physician

Last Name First Name Middle Initial Today's Date

Street Address City ZIP

Daytime phone# Evening phone# Physician

Did you eat or drink anything (but water) during the last 10 hours? Yes No Occupation: _____

AGE: _____ Male Female MARITAL STATUS: Single Married Divorced Widowed

One or both parents died before age 60: of Heart Disease? Yes No of Diabetes? Yes No

Check (X) if you have ever been told by a physician that you have any of the following:

<input type="checkbox"/> Angina (yr? _____)	<input type="checkbox"/> Abnormal EKG (last 3 yrs)	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Heart attack (yr? _____)	<input type="checkbox"/> Irregular heartbeats	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Angioplasty (yr? _____)	<input type="checkbox"/> Stroke (yr? _____)	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Bypass (yr? _____)	<input type="checkbox"/> High blood pressure: ____ / ____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Overweight
<input type="checkbox"/> Heart failure (yr? _____)	<input type="checkbox"/> High cholesterol _____	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Bronchitis/Emphysema
<input type="checkbox"/> Blood clotting problem	<input type="checkbox"/> High triglycerides _____	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Cancer: Type _____

List all Medications and Supplements you are presently taking on separate **Medication Form**. I take none

Please fill in the number of servings you eat or drink WEEKLY. If you don't use, then mark "0." Fill in every space, please.

Meat or Shellfish _____	Salad Dressings _____
Fowl or Fish _____	Mayonnaise _____
Whole Milk or 2% _____	Margarine _____
Cottage Cheese _____	Gravies _____
Butter or Cream _____	Soymeat/Gluten _____
Cheese _____	Soy Milk _____
Sour Cream _____	Water _____
Ice Cream/Ice Milk _____	Alcohol _____
Yogurt _____	Coffee/Tea _____
Liver/Organ meats _____	Soft Drinks _____
Sausage/Hotdogs _____	Candy or Sugar _____
Eggs _____	Sugary Desserts _____
Fried Foods _____	Honey or Syrups _____
Salty Snacks _____	Jam/Jelly/Custard _____

REST and STRESS

- Evening is biggest meal
- Eat little or no breakfast
- 6 hours or less sleep/night
- Sleep restlessly
- Suffer insomnia
- Work ____ hrs/week
- Very few vacations
- Feel under pressure
- Eat too fast
- Easily emotionally upset
- Feel muscular tension
- Eat between meals
- Feel fearful or depressed

EXERCISE

(beyond everyday occupation)

- None
- Mild 2-3 days/week
- Moderate 3-5 days/week
- Vigorous 4-6 days/week

BREATHING

- Non-smoker
- Ex-smoker (yr? _____)
- Smoker:
Years smoked: _____
Daily # of cigarettes: _____
How often tried to quit: _____
- Live with heavy smoker
- Asthma, hay fever
- Cough up phlegm or cigarette tar

FOR OFFICE USE ONLY

Height _____ Wt _____
Frame: Small Medium Large
Ideal weight _____
Blood pressure ____ / ____ mmHg
Pulse _____ per minute

RESULTS of blood test

_____ Glucose, Fasting
_____ Total Cholesterol
_____ LDL Cholesterol
_____ HDL Cholesterol
_____ Triglycerides
_____ Cholesterol ratio

RECOMMENDATION TO IMPROVE YOUR HEALTH BASED ON TESTS AND HEALTH HISTORY ABOVE

- Increase daily water to 8-10 glasses
- Lose/Gain weight _____
- Avoid cholesterol intake (*meats, sausages, fowl, fish, egg yolks, liver, ice cream, cheese*)
- Increase aerobic/walking exercise
- Substitute fruits, vegetables, potatoes for processed and refined foods
- Increase whole grains products (*breads, hot cereals, brown rice, etc.*)
- Reduce or eliminate salt.
- Reduce all dietary fat
- Reduce refined sugar
- Stop smoking
- Reduce/Eliminate caffeine
- Increase rest and relaxation
- Make breakfast biggest meal
- See your physician

RECOMMENDED PROGRAM

- Weight Management
- Stress Management
- Stop Smoking
- Low Cholesterol Meal management
- Low Salt Cookery
- Exercise/Walking Program

CHOLESTEROL	LDL
<input type="checkbox"/> Ideal <input type="checkbox"/> Elevated	<input type="checkbox"/> Ideal <input type="checkbox"/> Elevated
<input type="checkbox"/> High <input type="checkbox"/> Very High	<input type="checkbox"/> High <input type="checkbox"/> Very High
<input type="checkbox"/> Dangerously High	<input type="checkbox"/> Dangerously High

TRIGLYCERIDES
 Ideal Elevated
 High Dangerous

