Name:_____

DOB:_____ MRN:_____

Age:_____ Date:_____

Lifestyle and Risk Factor

Return Visit Questionnaire

Please complete and return to your healthcare provider

Do you have any symptoms or specific issues you'd like to discuss today? Yes ☐ No ☐

If yes, please describe: _____

Physical Activity:

Usual activity #1:_____ Sessions per week: _____ Minutes per session: _____

Usual activity #2:_____ Sessions per week: _____ Minutes per session: _____

Other Physical activity: _____

Since you last visit has your **overall physical activity level**: Decreased ☐ Stayed the same ☐ Increased ☐

Dietary Practices:

How many servings of **vegetables** are you eating per day? (1 serving = ½ cup cooked) _____

How many servings of **fruit** are you eating per day? (1 serving = medium apple) _____

How many servings of **whole grains** (brown rice, oatmeal) per day? (1 serving = ½ cup cooked) _____

How many servings (1 serving = ¼ pound) per week of **fish** _____, of **poultry (chicken or turkey)**_____

How many servings of **red meat** per week? (1 serving = ¼ pound) _____

How many **alcoholic drinks** (1 drink = 5 oz wine, 12 oz beer or 1½ oz liquor) do you have per week?_____

Since your last visit, is your eating pattern: Better ☐ No different ☐ Worse ☐

If different, in what ways? _____

Weight: Since your last visit, has **your weight**: Decreased □ Stayed the same □ Increased □

If changed, what accounts for this? _____

Smoking: Are you smoking? Yes □ No □ If yes, how many cigarettes per day? _____

Blood Pressure: Do you check your **blood pressure (BP) at home?** Yes □ No □

If yes, what is the typical range? Systolic BP (top #) _____ Diastolic BP (lower #) _____

Stress: How would you rate your overall **stress level**? Very low □ Low □ Moderate □ High □ Very high □

Mood: During the past month, have you often been bothered by:

Feeling down, depressed, or hopeless? Yes □ No □

Little interest or pleasure in doing things? Yes □ No □

Medications: Have your **medications changed** since your last visit? Yes □ No □

If yes, what has changed:_____

Are you having side effects from your medications? If yes, describe:_____

Diabetes: If you have diabetes, please complete the questions on the other side of this page.

Once you complete this form, please give to your healthcare provider for review during this appointment.

Checklist for patients with Diabetes:

Home glucose monitoring: Do you check your **blood sugar** regularly at home? Yes □ No □

If yes, what have your fasting readings been since your last visit?

Highest fasting glucose _____ Lowest fasting glucose _____ Typical fasting glucose _____

American Diabetes Association (ADA) Recommended Annual Examinations:

Have you had the following examinations during the last year?

Eye exam in the last year**?** Yes □ No □ Any problems noted? _____

Dental exam in the last year**?** Yes □ No □ Any problems noted? _____

Foot exam in the last year**?** Yes □ No □ Any problems noted? _____

ADA Recommended Medications: Are you taking the following medications?

If you **don't know, please ask your health care provider**:

Aspirin or similar drugs: Yes □ No □ Don't Know □

Statin (for cholesterol): Yes □ No □ Don't Know □

ACE inhibitor or ARB: Yes □ No □ Don't Know □
(for blood pressure)

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Once you complete this form, please give it to your healthcare provider for review during this appointment.

Revised: 10/08/2010
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