Date: **Name**_____ **DOB** _____

Preventive Visit

(Preventive Care Only please. Medical problems are not addressed at this type of visit)

Part 1

Diet (circle all that apply)

Regular Low salt Low fat Vegan Vegetarian Low carb Gluten-free
Mediterranean Pescatarian Other:

Exercise

Type: Hours per week:

Habits

Alcohol - What type of alcohol do you drink? How much?

Yes / No Have you ever felt you should cut down on your drinking?
Yes / No Have people annoyed you by criticizing your drinking?
Yes / No Have you ever felt bad or guilty about drinking?
Yes / No Have you ever had a drink first thing in the morning?

Smoking - Never / Current / Former

Type of tobacco: Amount: Years used: Year quit

Substances:

Yes / No Marijuana
Yes / No Other:

Emotional health

During the past 2 weeks, have the following been a problem for you:

Yes / No Little interest or pleasure in doing things
Yes / No Feeling down, depressed, or hopeless

Review of systems:

Please circle all that apply.

Constitutional: chills, fatigue, fever, malaise, night sweats, weight gain, weight loss

HEENT: hearing loss, ear pain, ear drainage, sinus pain/pressure, sore throat, nasal drainage, visual changes, eye pain, eye discharge

Respiratory: chronic cough, cough, shortness of breath, wheezing, known TB exposure

Cardiovascular: chest pain, pain in legs when walk, swelling, palpitations

Gastrointestinal: abdominal pain, change in stools, constipation, diarrhea, blood in stools, heartburn, loss of appetite, nausea, vomiting

Metabolic/Endocrine: intolerance of cold, intolerance of heat, excess thirst, excess hunger

Neurological: dizziness, extremity numbness, extremity weakness, difficulty with walking, headache, memory loss, seizures, tremors

Psychiatric: anxiety, depression, difficulty sleeping

Skin/hair: brittle hair, brittle nails, hair loss, excess body hair, hives, itchy skin, mole changes, rash, skin lesion

Musculoskeletal: back pain, joint pain, joint swelling, muscle weakness, neck pain

Hematologic/Lymph: easy bleeding, easy bruising, swollen lymph nodes
Immunologic: contact skin allergy, environmental allergies, food allergies, seasonal allergies
Genitourinary (male): dribbling, pain with urination, blood in urine, excess urination, slow stream, frequent urination, accidental urine loss, inability to empty bladder completely
Genitourinary (female): pain with urination, blood in urine, excess urination, frequent urination, accidental urine loss, inability to empty bladder completely
Reproductive (male): problems with erection, discharge from penis
Reproductive (female): abnormal PAP, pain with menstruation, pain with intercourse, hot flashes, irregular menstrual cycle, vaginal discharge, breast lump, nipple discharge

Legal (Anyone, but especially for those over 65)

Do you have a legal document that spells out your wishes should you become incapable of making decisions and naming a person to make those decisions for you?

Yes - Please provide us a copy for your medical records

No - We encourage you to fill out the Five Wishes form, available online at www.agingwithdignity.org. This is a simple form, legally recognized in California and 39 other states.

Part 2

Please update your previous histories on the printout. Feel free to add any missing items and scratch out any items.

Office Use Only *Q / LC* *F / NF* *Dx:*
Lipid *CMP* *CBC* *PSA* *Hgba1c* *Urine microalbumin* *U/A* *FOBT*
Mammo *DEXA* *Colonoscopy*
Flu *TdaP* *Pneumovax* *Prevnar 13* *Zostavax* *F/U*

AMERICAN COLLEGE OF Lifestyle Medicine

LOMA LINDA UNIVERSITY HEALTH
Produced in collaboration with Loma Linda University

Lifestyle Assessment Short Form

OVERALL HEALTH

1. Please circle your current overall LEVEL of HEALTH.

0 (Very poor health) 1 2 3 4 5 6 7 8 9 10 (Excellent health)

SLEEP

2. OVER THE LAST TWO WEEKS, how many hours of sleep did you average in a 24-hour period?

a. Less than 4 hours
b. 4-5 hours
c. 6 hours
d. 7-8 hours
e. 9 or more hours

3. OVER THE LAST TWO WEEKS, how often did you feel tired or have difficulty staying awake during routine tasks in the day?

a. Not at all
b. Several days
c. More than half the days
d. Nearly every day

WEIGHT MANAGEMENT

4. What do you think about your current weight?

a. I want to gain a lot of weight
b. I want to gain a little weight
c. I am happy with my weight
d. I want to lose a little weight
e. I want to lose a lot weight

NUTRITION

5. OVER THE LAST TWO WEEKS, how often have you eaten fast food, sugary drinks (e.g., soda, sports drinks, juice) or packaged foods (e.g., chips, candy, crackers, cookies)?

a. Not at all
b. Several days
c. More than half the days
d. Nearly every day

6. ON AN AVERAGE DAY, how many servings of whole fruits and vegetables do you eat (1 serving is about a handful and does not include fruit juice)?

a. Less than 2 servings
b. 2-3 servings
c. 4-5 servings
d. More than 5 servings

EXERCISE

7. OVER THE LAST TWO WEEKS, how many days did you exercise at a moderate to strenuous intensity (e.g., brisk walking or enough movement to break a light sweat)?

a. Less than 1 time per week
b. 1-2 times per week
c. 3-4 times per week
d. 5 or more times per week

8. DURING AN AVERAGE SESSION, how many minutes do you exercise at a moderate to strenuous intensity (e.g., brisk walking or enough movement to break a light sweat)?

a. Less than 10 minutes
b. 10-29 minutes
c. 30-49 minutes
d. 50 minutes or more

Patient Name:_____ DOB: _____

PURPOSE & CONNECTION / MENTAL HEALTH

9. Over the past 2 weeks, how often have you…	Not at all	Several days	More than half the days	Nearly every day
a. Felt like your life had purpose or meaning?	3	2	1	0
b. Connected with any support network (e.g. community, spiritual, friends/family, nature, yoga, or meditation)?	3	2	1	0
c. Been bothered by little interest or pleasure in doing things?	0	1	2	3
d. Been bothered by feeling down, depressed or hopeless?	0	1	2	3
e. Been bothered by feeling nervous, anxious or on edge?	0	1	2	3
f. Been bothered by worrying too much about different things?	0	1	2	3

SMOKING/SUBSTANCE USE

Have you used any of the following substances in the past year?

10. NICOTINE (cigarettes, e-cigarettes/vaping, cigars) Yes No

If you marked "YES", how many cigarettes do you usually use? _____ a day

If you marked "YES", circle what level of concern you have regarding nicotine? 0 (No Concern) 1 2 3 4 5 (High Concern)

11. ALCOHOL (beer, wine, liquor) Yes No

If you marked "YES", how much alcohol do you usually use? _____ a day

If you marked "YES", circle what level of concern you have regarding your alcohol use? 0 (No Concern) 1 2 3 4 5 (High Concern)

12. RECREATIONAL DRUGS (cocaine, heroin, meth, etc.) Yes No

If you marked "YES", how much do you usually use? _____ a day

If you marked "YES", circle what level of concern you have regarding your recreational drug use? 0 (No Concern) 1 2 3 4 5 (High Concern)

13. MARIJUANA Yes No

If you marked "YES", how much marijuana do you usually use? _____ a day

If you marked "YES", circle what level of concern you have regarding your marijuana use? 0 (No Concern) 1 2 3 4 5 (High Concern)

MOTIVATION

14. Please rank the top THREE areas you are most motivated to change in order to improve your current overall LEVEL OF HEALTH (1 being most motivated).

Sleep _____ Weight Management _____ Nutrition _____

Exercise _____ Purpose & Connection _____ Mental Health _____

Substance Use _____

What motivates you to be healthier? _____

_____

_____

Patient Name:_____ DOB: _____

Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐