CLEARWATER FAMILY MEDICINE

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Name: _____ **Date: _____**

LIFESTYLE QUESTIONNAIRE

The following questions refer to your lifestyle and how you take care of your health.

	YES	NO
1. Do you **chew tobacco**, **smoke tobacco**, or use a **vape product**?	___	___
If yes: How old were you when you started? _____		
How much do you smoke / chew per day? _____		
Have you tried to quit in the past? _____		
Are you ready to quit now? _____		
2. Do you drink alcohol?	___	___
If yes: What do you drink? ___Beer ___Wine ___Liquor / mixed Drinks		
How many drinks do you have per ___ Day ___ Week ___ Month?		
3. Do you or have you ever used **illicit drugs** or **abused prescription medications**?	___	___
4. Do you drink **caffeinated** beverages?	___	___
If yes: How many do you have in one day? _____		
5. Do you engage in **physical activity** on a regular basis?	___	___
If yes: How many days per week?_____		
Activity _____		
Duration _____		
6. Do you wear a **seat belt** regularly as both a passenger and a driver?	___	___
7. Are there any **hazardous exposures** at your work place?	___	___
8. Do you have any concerns about your **hearing**?	___	___
9. Do you see a **dentist** on a regular basis?	___	___
10. Do you see an **eye doctor** on a regular basis?	___	___
11. Do you ave any concerns about your **sleep**?	___	___

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Lifestyle Questionnaire continued ***YES*** ***NO***

12. Are you **sexually active**, or have been in the recent past? ___ ___

If yes: What is the gender of your partner? _____Male _____Female

How many partners have you had in the past year? _____

13. Are you currently using methods to **prevent pregnancy**? ___ ___

14. Do you have any **sexual concerns** or difficulties? ___ ___

15. Are you in any situation where you feel your **personal safety** is threatened? ___ ___

16. Over the past two weeks how often have you felt **down, depressed, or hopeless**?
____ Not at all ____Several days ____Most days ____Every day

17. Over the past two weeks how often have you been bothered by **little interest** or **pleasure in doing things**?
____ Not at all ____Several days ____Most days ____Every day

18. **For Women**: Do you perform **self breast exams** on a regular basis? ___ ___
Do you have any concerns? ___ ___

19. **For Men**: Do you perform **self testicular exams** on a regular basis? ___ ___
Do you have any concerns? ___ ___

_____ _____
Patient Signature Date

I have reviewed this questionnaire with the patient and addressed any areas of concern.

_____ _____
Physician Signature Date