Lifestyle and Medical History Questionnaire – BALANCE MEDICAL CENTER

Please complete the questionnaire as accurately and in as much detail as possible.
The information you provide will help the lifestyle doctor prepare for the consultation and make the most effective use of the time available.
All information will be treated in strict confidence.

Please return the completed questionnaire at least 3 days before the consultation.

1. BASIC DETAILS

Name: _____

Date of birth: _____ **Age:** _____

Telephone number: _____

Email address: _____

Address: _____

Occupation: _____

Nature of work: ☐ Desk-based work ☐ Physical work ☐ Mixed ☐ Working from home ☐ Shift work

2. WHY ARE YOU REQUESTING A LIFESTYLE MEDICAL CONSULTATION?

(Please explain how we can help you?)

_____

_____

_____

_____

_____

3. CURRENT STATE OF HEALTH

Please list all your known illnesses and chronic conditions:

Diagnosis	How long have you had it?	Who diagnosed it?

What symptoms are you currently experiencing?
(please tick all relevant symptoms and rate them on a scale of 1 to 10, where 10 is the most severe)

Symptom	1–10	Since when?	Comments
Fatigue, exhaustion			
Sleep problems			
Digestive problems			
Headache			
Joint pain			
Back pain			
Difficulty breathing			
Chest pain/tightness			
Dizziness			
Skin problems			
Difficulty concentrating			
Mood problems			
Overweight			
Other:			

4. MEDICAL HISTORY

Previous serious illnesses, operations, accidents – please list them in chronological order:

_____

_____

_____

_____

_____

_____

Hospital admissions and operations in the last 5 years

_____

_____

_____

_____

Allergies

☐ I have no known allergies

☐ I have allergies, namely:

_____

Food allergies, food intolerances

☐ None

☐ I do, namely:

_____

5. FAMILY MEDICAL HISTORY

Please tick if any of the following have occurred in your close relatives (parents, siblings, grandparents), and if you know at what age:

Condition	Relative affected	Age at diagnosis
☐ Heart attack		
☐ Stroke, cerebral haemorrhage		
☐ Diabetes		
☐ High blood pressure		

☐ High cholesterol		
☐ Cancer (type: _____)		
☐ Autoimmune disease		
☐ Obesity		
☐ Depression, anxiety		
☐ Dementia, Alzheimer's disease		
☐ Other: _____		

6. MEDICINES AND SUPPLEMENTS

Please list all medicines, stating their exact names and dosages

Name of medicine	Dosage	How long have you been taking it?	What are you taking it for?

Vitamins, minerals, dietary supplements

Name of product	Dosage	How long have you been taking it?

Previous medicines that caused side effects:

_____

_____

_____

_____

7. DIET -

How many main meals do you eat each day? ☐ 1 ☐ 2 ☐ 3 ☐ 4+

How many snacks do you have between meals? ☐ 0 ☐ 1–2 ☐ 3–4 ☐ More

How often do you usually have breakfast? ☐ Never ☐ Rarely ☐ At the weekend ☐ Every day

Your typical breakfast: _____

Your typical lunch: _____

Your typical dinner: _____

What do you usually snack on? _____

Consumption of food groups

Please indicate how often you eat the following foods:

Food	Never	Rarely	1–2 times a week	3–5 times a week	Daily
Vegetables (raw)	☐	☐	☐	☐	☐

Vegetables (cooked)	☐	☐	☐	☐	☐
Fruit	☐	☐	☐	☐	☐
Wholemeal grains	☐	☐	☐	☐	☐
White bread, pastries	☐	☐	☐	☐	☐
Pulses (beans, lentils, etc.)	☐	☐	☐	☐	☐
Nuts and seeds	☐	☐	☐	☐	☐
Red meat (beef, pork, lamb)	☐	☐	☐	☐	☐
Poultry, fowl	☐	☐	☐	☐	☐
Fish	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐
Dairy products	☐	☐	☐	☐	☐
Processed meat (cold cuts, sausages)	☐	☐	☐	☐	☐
Sweets, cakes, sugar	☐	☐	☐	☐	☐
Salty snacks (crisps, crackers)	☐	☐	☐	☐	☐
Fast food	☐	☐	☐	☐	☐

Fluid intake

How much water do you drink each day? _litres

Other fluids (daily intake):

- Coffee: _____cups
- Tea: _____cup
- Soft drinks, fruit syrups: ___glass
- 100% fruit juice: _____glass
- Energy drink: _____can
- Other: _____

Eating environment and habits

Where do you usually eat? ☐ At home, I cook for myself ☐ Canteen ☐ Restaurant ☐ Fast-food outlets ☐ Mixed

How many times a week do you eat out? _____times

How quickly do you eat? ☐ Very quickly (in under 10 minutes) ☐ Moderately (15–20 minutes) ☐ Slowly, chewing thoroughly (25+ minutes)

What do you do whilst eating? ☐ Just eat ☐ Watch TV or films ☐ Talk on the phone ☐ Working, reading

When do you eat the most? ☐ In the morning ☐ At midday ☐ In the evening ☐ At night

Do you typically eat at night? ☐ Yes ☐ No

Special diets

Do you follow any special diet? ☐ No ☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Lactose-free ☐ Paleo ☐ Keto ☐ Other: _____

If so, for how long? _____

Why did you choose it? _____

Eating habits

Does this apply to you? (you may tick more than one)

☐ Eating out of boredom
☐ Eating due to stress
☐ Emotional eating
☐ Binge eating (consuming large amounts in a short period of time)
☐ Secret eating
☐ Feeling guilty after eating
☐ Constant dieting
☐ Excessive control over food

Do you tend to ignore your feelings of hunger? ☐ Yes ☐ No ☐ Sometimes

Can you recognise when you're full? ☐ Yes ☐ No ☐ Sometimes

Previous attempts at dieting/weight loss

How many diets have you tried before? _____

What sort of diets? _____

What were the long-term results? ☐ You lost weight permanently ☐ You put the weight back on ☐ Yo-yo effect

☐ You were unable to lose weight

8. PHYSICAL ACTIVITY

How active are you during an average day? ☐ Very sedentary (I sit all day) ☐ Slightly active (occasional walking, standing) ☐ Moderately active (regular walking, exercise) ☐ Very active (physical work or intense sport)

How many steps do you take on average each day? _____(if you count them)

Do you exercise regularly? ☐ Yes ☐ No

If yes:

Type of activity	Frequency (e.g. weekly)	Duration	Intensity
			☐ Light ☐ Moderate ☐ Intense
			☐ Light ☐ Moderate ☐ Intense
			☐ Easy ☐ Moderate ☐ Intense

Do you have a regular exercise plan or a trainer? ☐ Yes ☐ No

What prevents you from exercising regularly? ☐ Lack of time ☐ Fatigue ☐ Pain

☐ Lack of motivation ☐ No obstacles ☐ Other: _____

Do you enjoy exercise? ☐ Yes ☐ No ☐ Mixed

What kind of exercise would you be interested in? _____

Sensitivity to movement, limitations

Are there any physical limitations that hinder your mobility? ☐ Yes ☐ No

If so, what: _____

Have you ever had any musculoskeletal injuries?_____

9. SLEEP

Sleeping habits

How many hours do you sleep on average each

night?

_____ho

urs **Is this enough for you?** ☐ Yes ☐ No

When do you usually go to bed? : When do you get up? :

Is your sleep routine different at the weekend? ☐ Yes ☐ No

Sleep quality

How would you rate the quality of your sleep? ☐ Very poor ☐ Poor ☐ Average ☐ Good ☐ Excellent

Does this apply to you? (you may tick more than one)

☐ You find it difficult to fall asleep

☐ I often wake up during the night

☐ Wake up early and cannot get back to sleep

☐ Feels well-rested in the morning

☐ Daytime tiredness and drowsiness

☐ Snoring

☐ Breathing pauses during sleep (noticed by partner)

☐ Restless legs syndrome

☐ Nightmares

Do you take sleeping pills or tranquillisers? ☐ Yes ☐ No

If so, what and how often? _____

Bedtime routines

What do you do 1–2 hours before going to bed? ☐ Screen time (phone, tablet, TV) ☐ Reading

☐ Work ☐ Relaxation, meditation ☐ Other: _____

When do you have your last meal? :

Do you consume caffeine in the afternoon/evening? ☐ Yes ☐ No

10. STRESS AND MENTAL HEALTH

Stress levels

How would you rate your current stress level? (1–10, where 10 is the worst)

_____

What causes you stress? (you may select more than one)

☐ Work, career

☐ Finances

☐ Family problems

☐ Relationship

☐ Health (your own or a family member's)

☐ Being alone, loneliness

☐ Worries about the future

☐ Other: _____

Coping strategies

How do you cope with stress? (you may select more than one)

☐ Talking to friends and family
☐ Sport, exercise
☐ Meditation, breathing exercises
☐ Hobbies
☐ Walking in nature
☐ Eating and drinking
☐ Smoking
☐ Alcohol
☐ Withdrawal, isolation
☐ I don't worry about it
☐ Other: _____

Mental wellbeing

How often have you felt the following over the past 2 weeks?

Symptom	None	On a few days	For more than half a day	Almost every day
Low mood, depression	☐	☐	☐	☐
Lack of interest or joy	☐	☐	☐	☐
Anxiety, nervousness	☐	☐	☐	☐
Worries that are difficult to control	☐	☐	☐	☐

Have you ever been diagnosed with a mental health problem? ☐ No ☐ Depression ☐ Anxiety ☐ Panic attacks ☐ Other: _____

Are you taking antidepressants or anti-anxiety medication? ☐ Yes ☐ No

If so, which ones? _____

Do you see a psychologist or psychiatrist? ☐ Yes ☐ No

11. SOCIAL RELATIONSHIPS

How would you rate your social relationships? ☐ Very satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very dissatisfied

Is there anyone you can count on if you need help? ☐ Yes, there are several people ☐ Yes, 1–2 people ☐ No

Are you in a relationship? ☐ Yes ☐ No

If so, does your partner support you in adopting a healthy lifestyle? ☐ Very supportive ☐ Supportive ☐ Neutral ☐ Not supportive

Do you live with family or others in your household? ☐ Yes ☐ No, I live alone

How much time do you spend socialising each week? ___hours

Do you ever feel lonely? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

12. ADDICTIONS AND HARMFUL HABITS

Do you smoke? ☐ No, I've never smoked ☐ I used to smoke, but _____I gave it up years ago ☐ Yes, I still smoke

If you currently smoke:

- Number of cigarettes per day: _____cigarettes
- How many years have you been smoking: _years

- Would you like to give up? ☐ Yes ☐ No ☐ I don't know

Do you drink alcohol? ☐ No, never ☐ Occasionally (1–2 times a month) ☐ 1–2 times a week ☐ 3–5 times a week ☐ Every day ☐ I used to drink more, but_____I haven't for years.

Do you use psychoactive substances? ☐ No ☐ Yes, which ones: _____

Do you have any behavioural addictions? (internet, shopping, gaming, pornography, etc.)

13. LAB RESULTS AND TESTS

Please enter the most recent known values and the date of the test:

Test	Result	Date	Normal range
Body weight	kg		
Height	cm		
Waist circumference	cm		
Blood pressure	/ mmHg		
Fasting blood glucose	mmol/l		3.9–5.6
HbA1c	%		<5.7%
Total cholesterol	mmol/l		<5.2
LDL cholesterol	mmol/l		<3.4
HDL cholesterol	mmol/l		>1.0 (men), >1.2 (women)
Triglycerides	mmol/l		<1.7
GOT (AST)	U/l		
GPT (ALT)	U/l		
GGT	U/l		
Creatinine	μmol/l		
Vitamin D	nmol/l		>75
TSH	mU/l		0.4–4.0
CRP	mg/l		<3

Do you have any recent (no more than 3 months old) laboratory results? ☐ Yes ☐ No
If so, please attach the test results or bring them with you to the consultation.

14. PREVIOUS ATTEMPTS TO CHANGE YOUR LIFESTYLE

Have you tried to change your lifestyle before? ☐ Yes ☐ No

If so, what did you try and what were the results?

_____

_____

_____

_____

What was the biggest obstacle to making the change?

_____

_____

_____

_____

What helped you the most in making the change?

_____

_____

_____

_____

15. MOTIVATION AND READINESS TO CHANGE

How prepared do you feel to make a lifestyle change?

☐ I'm not prepared at all ☐ I'm thinking about it, but I'm not sure yet

☐ I'm ready for change ☐ I've already started making changes

☐ I've been maintaining healthy habits for a long time

What motivates you to make a change? (you may select more than one option)

☐ Improving health issues
☐ Reducing or stopping medication
☐ Losing weight
☐ Increasing energy levels
☐ Improving quality of life
☐ Prevention (I don't want to get ill)
☐ Setting an example for my children
☐ A longer, healthier life
☐ Other: _____

How confident are you that the change will be successful? (1–10) _____

What do you consider to be the biggest challenge?

_____

_____

_____

_____

_____

_____

16. OTHER INFORMATION

Is there anything else you feel is important to share but which wasn't covered in the questionnaire?

_____

_____

_____

_____

_____

_____

_____

_____

DECLARATION

I declare that the information provided in this questionnaire is true and accurate.
I acknowledge that the information provided or withheld may affect the outcome of the medical consultation.

Date: _____ Signature: _____

Thank you for taking the time to complete this questionnaire!
Please return the completed questionnaire by email or via the online form at least 3 days before the consultation.

Thank you for your trust!