

Health Questionnaire

Information:

Name: _____ Age: _____ Gender: _____

Email: _____ Weight: _____ Height: _____

Hours worked per week: < 10 10-20 21-40 >40

Hours of sleep each night: <6 6-7 7-8 >8

Do you use tobacco? Yes/No

If so, how often do you use tobacco? Daily/ Less than Daily

Would you be interested in materials on quitting tobacco? Yes/No

Medical:

Please circle any of the following for which you have been diagnosed or treated by a physician or health professional:

Alcoholism	Anemia	Asthma	Back strain	Bronchitis
Cancer	Cirrhosis-liver	Diabetes I or II	Emphysema	Gout
Heart problems	High Blood Pressure	Hypoglycemia	High Cholesterol	Kidney problems
Obesity	Rheumatoid arthritis	Stroke	Thyroid	Ulcer

Other: _____

If you circled any of the above please explain: _____

Do you currently take any medications that interfere with food intake? _____

Diet:

Please circle.

Breakfast consumption: Daily Sometimes Skip Breakfast

Fruits & vegetables: ≥ 5 servings daily 2-4 servings 1 or less

How many meals do you eat outside of the home per week? 0-2 3-5 6-8 9 or more

Do you find yourself skipping meals, if so, how often? _____

Do you currently take any dietary supplements? If so please list them: _____

Do you have any known food allergies? _____

Physical Activity:

Are you currently exercising? Yes/No

If yes, what are you currently doing? _____

How long do you exercise? _____ How often per week? _____

If no, when was the last time you regularly exercised? _____

What are your health goals? _____

Please list any other diet/health concerns you would like more information on: _____

For questions, contact Jenni Wolf at (309) 438-1882. Please return with 3 food diaries via campus mail Campus Box 2120, fax to (309) 438-5003, or visit us at 187 McCormick Hall.



**HEALTH PROMOTION
AND WELLNESS**
Illinois State University