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 Ally Engle 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.