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EXECUTIVE PHYSICIANS
INTERNAL MEDICINE

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Optimal Health Questionaire

In order to improve your health, how willing are you to:

	very willing 5	4	3	2	1 not willing at all
Significantly modify your diet	❑	❑	❑	❑	❑
Take several nutritional supplements each day	❑	❑	❑	❑	❑
Modify your lifestyle (e.g., work, demands, sleep habits)	❑	❑	❑	❑	❑
Engage in regular exercise	❑	❑	❑	❑	❑

Comments: _____

_____

_____

	very supportive 5	4	3	2	1 very unsupportive
At the present time, how supportive do you think the people in your household will be to your implementing the above changes?	❑	❑	❑	❑	❑

Comments: _____

_____

_____

3 Day Diet Diary Instructions

It is important to keep an accurate record of your usual food and beverage intake as part of your treatment plan. Please complete this diet diary for 3 consecutive days including one week-end day. Do not change your eating behavior at this time as the purpose of this food record is to analyze your present eating habits. Record information as soon as possible after the food has been consumed. Describe the food or beverage as accurately as possible e.g., milk what kind? (whole, 2%, nonfat); toast - (whole wheat, white , buttered); chicken - (fried, baked, breaded) coffee - (decaffeinated with sugar and ½ & ½). Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, etc. Include any additional comments about your eating habits on this form (ex. Craving sweet, skipped meal and why, when the meal was at a restaurant, etc).

Diet Diary

Day 1: Food Type Amount consumed

Eating habits:

Day 2: Food Type Amount consumed

Eating habits:

Day 3: Food Type Amount consumed

Eating habits:

Have you ever had a nutrition consultation? ❑ Yes ❑ No

Have you made any changes in your eating habits because of your health? ❑ Yes ❑ No
If yes, please describe: _____

_____

_____

Do you currently follow a special diet or nutritional program? ❑ Yes ❑ No

Check all that apply:

- ❑ Low Fat
- ❑ Low Carbohydrate
- ❑ High Protein
- ❑ Low Sodium
- ❑ Diabetic
- ❑ No Dairy
- ❑ No Wheat
- ❑ Gluten Restricted
- ❑ Vegetarian
- ❑ Vegan
- ❑ Ultrametabolism
- ❑ Atkins
- ❑ South Beach Diet
- ❑ Mediterranean Diet
- ❑ Specific program for weight loss/maintenance type
- ❑ Paleo
- ❑ other

Do you avoid any particular foods? ❑ Yes ❑ No
If yes, type and reason: _____

_____

If you could only eat a few foods a week, what would they be?

_____

_____

Do you grocery shop? ❑ Yes ❑ No
If not, who does the shopping?

_____

_____

Do you read food labels? ❑ Yes ❑ No

Do you cook? ❑ Yes ❑ No
If not, who does the cooking ?

_____

_____

How many meals do you eat per day?

_____

_____

Check all the factors that apply to your current lifestyle and eating habits:

- ❑ Fast eater
- ❑ Erratic eating pattern
- ❑ Eat too much
- ❑ Late night eating
- ❑ Dislike healthy food
- ❑ Time constraints
- ❑ Eat more than 50% of meals away from home
- ❑ Travel frequently
- ❑ Non-availability of health foods
- ❑ Do not plan meals or menus
- ❑ Reliance on convenience items
- ❑ Poor snack choices
- ❑ Significant other or family members don't like healthy foods
- ❑ Significant other or family members have special diatery needs or food preferences
- ❑ Love to eat
- ❑ Eat because I have to
- ❑ Have a negative relationship to food
- ❑ Struggle with eating issues
- ❑ Emotional eater (eat when sad, lonely, depressed, bored)
- ❑ Eat too much under stress
- ❑ Eat too little under stress
- ❑ Don't care to cook
- ❑ Eating in the middle of the night
- ❑ Confused about nutrition advice

Exercise:

Current exercise program: activity (list type, number of sessions/ week, and duration of activity)

Activity type	frequency per week	duration in minutes
Stretching	_____	
Cardio/aerobics	_____	
Strength	_____	
Other (yoga, pilates, gyrotonics, etc)	_____	
Sport or leisure activities (golf, tennis, rollerblading, etc .)	_____	

Rate your level of motivation for including exercise in your life? ❑ Low ❑ Medium ❑ High

List problems that limit activity: _____

_____

_____

_____

Do you feel unusually fatigued after exercise? ❑ Yes ❑ No

if yes, please describe _____

_____

Do you feel significantly less vital than you did a year ago? ❑ Yes ❑ No

Are you happy? ❑ Yes ❑ No

Do you feel your life has meaning and purpose? ❑ Yes ❑ No

Do you believe stress is presently reducing the quality of your life? ❑ Yes ❑ No

Do you like the work you do? ❑ Yes ❑ No

Have you ever experienced major losses in your life? ❑ Yes ❑ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ❑ Yes ❑ No

Would you describe your experience as a child in your family as happy and secure? ❑ Yes ❑ No

Stress/coping

Have you ever sought counseling? ❑ Yes ❑ No

Are you currently in therapy? ❑ Yes ❑ No
If yes, describe _____

_____

Do you feel you have an excessive amount of stress in your life? ❑ Yes ❑ No

Do you feel you can easily handle the stress in your life? ❑ Yes ❑ No

Daily stressors: Rate on scale of 1-10

work _____ family _____ social _____ finances_____ health_____ other _____

Do you practice meditation or relaxation technique? ❑ Yes ❑ No If yes, how often _____

Check all that apply: ❑ Yoga ❑ Meditation imagery ❑ Breathing ❑ Tai chi ❑ Prayer ❑ Other

Have you ever been abused, victim of crime, or experienced a significant trauma? ❑ Yes ❑ No

Sleep/rest

Average number of hours you sleep per night ? _____

Do you have trouble falling asleep? ❑ Yes ❑ No Staying asleep? ❑ Yes ❑ No

Do you feel rested upon awakening? ❑ Yes ❑ No

Roles/relationship

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Gay/lesbian ❑ Long term partnership ❑ Widow

Are you satisfied with your sex life? ❑ Yes ❑ No

How well have things been going for you?

overall	❑ very well	❑ fine	❑ poorly	❑ does not apply
at school	❑ very well	❑ fine	❑ poorly	❑ does not apply
in your job	❑ very well	❑ fine	❑ poorly	❑ does not apply
in your social life	❑ very well	❑ fine	❑ poorly	❑ does not apply
with close friends	❑ very well	❑ fine	❑ poorly	❑ does not apply
with sex	❑ very well	❑ fine	❑ poorly	❑ does not apply
with attitude	❑ very well	❑ fine	❑ poorly	❑ does not apply
with your boyfriend/ girlfriend	❑ very well	❑ fine	❑ poorly	❑ does not apply
with your children	❑ very well	❑ fine	❑ poorly	❑ does not apply
with your parents	❑ very well	❑ fine	❑ poorly	❑ does not apply
with your spouse	❑ very well	❑ fine	❑ poorly	❑ does not apply

Enviromental and Detoxification Assessment

Do you have known adverse food reaction or sensitivities? ❑ Yes ❑ No
if yes, describe symptoms _____

_____

Do you have any food allergies or sensitivities? ❑ Yes ❑ No
if yes, list all _____

_____

Do you have an adverse reaction to caffeine? ❑ Yes ❑ No

Do you have any known history of significant exposure to any harmful chemicals such as the following:
❑ Herbicides ❑ Insecticides (frequent visits of exterminator) ❑ Pesticides ❑ Organic solvents
❑ Heavy metals ❑ Other

Chemical name? _____ Date _____ Length of exposure _____

Do you or have you lived or worked in damp or moldy environment or had other mold exposures? ❑ Yes ❑ No

Do you have any pets or farm animals? ❑ Yes ❑ No

Smoking:
Currently smoking? ❑ Yes ❑ No
How many years?_____ Packs per day: _____ Attempts to quit: _____

Previous Smoker: How many years?_____ Packs per day: _____

2nd hand smoke exposure? ❑ Yes ❑ No

Alcohol Intake:
How many drinks currently per week? (1 drink = 5 ounces wine, 12 oz beer, 1.5 ounces spirits)

_____

Other substances:
Caffeine intake? ❑ Yes ❑ No
Cups/day coffee; tea ❑ 1 ❑ 2-4 ❑ >4 a day

Soda or diet soda intake? ❑ Yes ❑ No
How many servings daily?

_____

In general, would you say your health is:

❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor

Compared to one year ago, how would you rate your health in general now? (please check one box.)

❑ Much better than one year ago
❑ Somewhat better now than one year ago
❑ About the same as one year ago
❑ Somewhat worse now than one year ago
❑ Much worse now than one year ago

How TRUE or FALSE is each of the following statements for you?

	Definitely True	Mostly True	Don't know	Mostly False	Definitely False
I seem to get sick a little easier than other people	❑	❑	❑	❑	❑
I am as healthy as anybody I know	❑	❑	❑	❑	❑
I expect my health to get worse	❑	❑	❑	❑	❑
My health is excellent	❑	❑	❑	❑	❑