



HILL PARK MEDICAL CENTER

LIFESTYLE AND HABITS

MEDICAL CENTER

Name: _____ Date: _____

Describe a typical meal:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

To Drink _____

Do you:	Yes	No	
Average 6-8 hours sleep?			What are your three favorite foods? _____ _____ _____ What three foods do you dislike the most? _____ _____ _____ _____
Have a supportive relationship?			
Have a history of abuse?			
Have a history of trauma?			
Enjoy your work?			
Take Vacations?			
Spend time outside?			
Watch Television?			How many hours weekly?
Read Books?			How many hours weekly?
Computer games/browsing?			How many hours weekly?
Spiritual / religious practice?			Please describe:
Do you smoke?			How much?
Did you smoke in the past?			How many years? How many packs?
Do you eat three meals per day?			
Do you eat out often?			How many meals a week?
Do you drink coffee?			How many cups?
Do you drink tea?			How many cups?
Do you drink soft drinks?			How many a day?
Do you use sugar?			How much?
Use alcoholic beverages?			How often?