Name: Date:

PATIENT LIFESTYLE QUESTIONNAIRE

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Answer the following questions about you

1 What time do you go to bed? How many hours do you usually sleep?

2 What do you usually have for breakfast?

3 Do you do exercise every day? What do you do?

4 Do you eat fruits and vegetables? Which are your favorites?

5 How many hours do you spend watching TV / videos?

6 Do you smoke? If yes, how often do you smoke?

7 Do you consume alcohol? If yes, how often do you drink alcohol?

8 How much water do you drink every day?

9 How often do you eat fast food?

10 How many hours a day do you remain sitting at work and home?