

LIFESTYLE PROGRAM

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Lifestyle Questionnaire

Take action to improve your health with the Boston Heart Lifestyle Program.*

1

Complete this questionnaire to unlock several tools including your Personalized Nutrition and Life Plan and support from a Registered Dietitian Coach.

2

Completely fill in the circles that correspond with your answers. Carefully review your responses and make sure all fields have been answered.

Correct: ● Incorrect: ⊗ ⊗ ⊗

3

Once finished, hand your questionnaire to the staff member* drawing your sample. The questionnaire will be sent back to Boston Heart.

*If you have already completed your blood draw, questionnaires can be mailed to Boston Heart via our business reply envelopes or faxed to 508.663.5484.

FIRST NAME: _____ LAST NAME: _____

EMAIL ADDRESS: _____

PHONE NUMBER: _____

HOME ADDRESS: _____

MALE

FEMALE

DATE OF BIRTH: _____

*Prior to completing this questionnaire, talk to your healthcare provider about your Boston Heart testing. Seven tests are used to drive the advanced algorithm that generates the Life Plan. To review the Boston Heart Diagnostics Notice of Privacy Practices, go to mybostonheart.com or call 877.425.1252.



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ABOUT ME

This information will be used to determine both your heart health and nutrition recommendations.

HISTORY OF HEART DISEASE & DIABETES

- Y N I have heart disease
- Y N I have had a heart attack
- Y N I have had a stroke
- Y N I have had heart bypass surgery or angioplasty and/or stent to treat blockages in my heart
- Y N My parents or siblings had premature heart disease (before age 55 for father/brother or before age 65 for mother/sister; if unknown, select No)
- Y N I have diabetes
- Y N I have prediabetes
- Y N My parents have or had diabetes (if unknown, select No)
- Y N I have high blood pressure (hypertension)
- Y N I currently smoke cigarettes
- Y N My healthcare provider has recommended a diet low in protein because of my low kidney function
- Y N I am pregnant or nursing

MEDICATIONS & SUPPLEMENTS

- Y N I currently take a statin or my doctor has recommended that I take a statin to lower my cholesterol (Rosuvastatin [Crestor®], Atorvastatin [Lipitor®], Simvastatin [Zocor®], Pravastatin [Pravachol®], Fluvastatin [Lescol®])
- Y N I take Red Yeast Rice
- Y N I take ezetimibe (Zetia®)
- Y N I take niacin (including Niaspan®)
- Y N I take a fish oil or Omega-3 Fatty Acid supplement
- Y N I take medication to lower blood pressure
- Y N I take medication to treat diabetes or prediabetes
- Y N I take insulin to treat diabetes



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HOW WOULD YOU DESCRIBE YOURSELF? (Select all that apply)

Race and ethnicity can impact risk. This information will help personalize your plan more.

- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Hispanic or Latino
- Other
- I prefer not to answer

WHY ARE YOU JOINING THE LIFESTYLE PROGRAM? (Select all that apply)

- My healthcare provider encouraged me to make lifestyle changes
- I want to improve my health
- I want to lose weight
- I want to feel better
- My test results are red, indicating I am at increased risk for heart disease
- I have heart disease, diabetes, prediabetes and/or high blood pressure
- I want to take fewer medications
- I want advice from a Registered Dietitian about food and exercise
- Other

WHICH OPTION BEST DESCRIBES YOUR READINESS TO MAKE CHANGES TO YOUR EATING AND PHYSICAL ACTIVITY ROUTINE?

- I'm currently maintaining changes I've made
- I'm currently trying to make changes
- I'm ready to make changes
- I'm not ready to make changes
- I'm unsure

FOOD AND MENU PREFERENCES

This information will help determine the total amount of healthy proteins, carbs and fats recommended in your plan and provide you with a personalized food list and menu.

SPECIAL MENU REQUEST

Which menu option best meets your dietary needs? (Select only one)

- Classic (no special menu request)
- Dairy-Free
- Gluten-Free
- Dairy-Free & Gluten-Free
- Nut Free
- Vegetarian (plant-based but includes eggs and dairy)
- Vegetarian & Nut Free
- Vegan (plant-based only)



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FOOD PREFERENCES

This information will be used to remove foods you will not eat from your personalized food list and menu.

For each of the foods below, select if you like, are willing to try or will not eat.

	LIKE	WILLING TO TRY	WILL NOT EAT		LIKE	WILLING TO TRY	WILL NOT EAT
FRUITS				LEAN PROTEINS			
Berries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fish	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Apples	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tuna (canned)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oranges	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Shellfish	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
VEGETABLES				Chicken	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Carrots	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Turkey	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Broccoli	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pork	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sweet potatoes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Beef	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Green beans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Protein powder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cabbage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Breakfast smoothies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LEGUMES				Eggs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chick peas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	DAIRY PRODUCTS			
Beans (kidney, black, red)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Milk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Edamame	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cheese	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lentils	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yogurt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hummus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cottage cheese	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GRAINS				SOY PRODUCTS			
Rice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tofu	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quinoa	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Soy milk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pasta	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	NUTS AND FATS			
Bread	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Avocado	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tortilla	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Nuts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Nut butter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

YOUR MEAL PREFERENCES

For each question, select a number on a scale from 0 to 10 to indicate the amount of each nutrient you like in your meals.

How much healthy lean proteins do you like in your meals?

Some examples of healthy proteins are lean meat, poultry, fish, egg whites, beans, soy and low-fat cheese.



0 1 2 3 4 5 6 7 8 9 10

I like my meals to have little lean proteins

Neutral

I like my meals to have a lot of lean proteins



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REGARDING MY CURRENT WEIGHT

- I would like to gain weight I would like to lose weight*
- I believe I am at the right weight I know I should lose weight, but do not want to

*IF YOU WOULD LIKE TO LOSE WEIGHT:

On a scale of 1 to 5, how aggressive do you want to be with your weight loss plan?

By selecting very aggressive, your plan will have the lowest calorie target and highest weight loss goal possible.

Not aggressive 1 2 3 4 5 Very aggressive

PHYSICAL ACTIVITY

Physical activity is any movement of your body above and beyond your daily routine (examples include walking, running, and weight lifting).

PHYSICAL ACTIVITY LEVEL (Select one statement that best applies to you)

- I do less than 30 minutes of physical activity fewer than 3 days per week
- I do about 30 minutes of physical activity 3-4 days per week
- I do about 30 minutes to 1 hour of physical activity 5 days per week
- I do 1 hour or more of physical activity at least 5 days per week
- I have mobility limitations due to a health condition or am physically challenged

I CURRENTLY ENJOY OR WOULD LIKE TO BEGIN THE FOLLOWING ACTIVITIES (Select all that apply)

- I'm unable or unwilling to do any of these activities

CARDIO

- Walking
- Hiking
- Running
- Swimming
- Rowing
- Skiing
- Dancing
- Biking

- Elliptical
- Yard work
- Stairmaster

SPORTS

- Basketball
- Soccer
- Tennis
- Golf

STRETCHING

- Stretching
- Yoga
- Pilates
- Tai Chi

STRENGTH TRAINING

- Strength training/Weight lifting
- Calisthenics (push-ups, sit-ups, lunges, etc.)

GROUP CLASSES OR VIDEOS

- Organized fitness classes
- Exercise videos
- Zumba®
- Kickboxing
- Water aerobics

