

# LIFE QUESTIONS

Steinmetz Medical Associates P.C.

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient's Name \_\_\_\_\_

Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*These questions are to help the doctor to get to know you. Feel free to skip any you do not feel comfortable answering.*

Do you eat meat? Yes No If so, how often? \_\_\_\_\_

How many fruits do you eat per day? \_\_\_\_\_ Vegetables? \_\_\_\_\_

What exercise(s) do you do weekly (type, frequency, and how long)?

\_\_\_\_\_  
\_\_\_\_\_

Are you sexually active? Yes No Sexual preference? \_\_\_\_\_

What has been your greatest challenge in life? \_\_\_\_\_

What has been your greatest disappointment? \_\_\_\_\_

What has been your greatest joy? \_\_\_\_\_

## Review of Systems

*(circle all that apply over the last 6 months)*

- |            |                 |                    |                       |
|------------|-----------------|--------------------|-----------------------|
| Fever      | Weight Loss     | Loss of Appetite   | Trouble Sleeping      |
| Headaches  | Eye Problems    | Ear Problems       | Nose Problems         |
| Hay Fever  | Throat Problems | Swollen Glands     | Change in Mole        |
| New Lump   | Cough           | Chest Pain         | Heart Palpitations    |
| Heartburn  | Abdominal Pain  | Constipation       | Difficulty Swallowing |
| Diarrhea   | Blood in Stool  | Back Pain          | Difficulty Urinating  |
| Joint Pain | Joint Swelling  | Skin Abnormalities | Menstrual Problem     |

Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_