BIO | ANALOGICS®

LONGEVITY INDEX

LIFESTYLE QUESTIONNAIRE

_______/_______/________
DATE OF ANALYSIS

NAME

ADDRESS

CITY STATE ZIP

(______)__________________________
HOME PHONE

(______)______________________
WORK PHONE

______/______/______
DATE OF BIRTH

❑ M ❑ F
SEX

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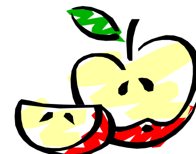
How to complete the questionnaire.

The information you supply in the following *LONGEVITY INDEX* questionnaire will be used to develop a profile of your current risk status for coronary heart disease, cancer and other lifestyle related concerns. All of the information you provide is strictly confidential.

Honest and accurate answers will provide a meaningful LONGEVITY INDEX report. You should read and understand each question thoroughly and then place an "X" in front of each appropriate response.



Patient: ___________________________________ Date: ____________________

Section A
Non-Controllable Risk Factors

1.0 Family history of Coronary Heart Disease occurring before 60 years old.

Indicate the number of members of your direct family who have died or been diagnosed with Coronary Heart Disease before the age of 60.

❑ None ❑ 1 person ❑ More than 1

2.0 Family history of Coronary Heart Disease occurring after 60 years old.

Indicate the number of members of your direct family who have died or been diagnosed with Coronary Heart Disease after the age of 60.

❑ None ❑ 1 person ❑ More than 1

3.0 Family history of Diabetes.

Indicate the number of members of your direct family who have been diagnosed with diabetes.

❑ None ❑ 1 person ❑ More than 1

4.0 Family history of Strokes or Cerebral Vascular Disease.

Indicate the number of members of your direct family who have died or been diagnosed with Strokes or Cerebral Vascular Disease.

❑ None ❑ 1 person ❑ More than 1

5.0 Personal history of cancer

Have you ever been diagnosed with any type of cancer?

❑ Yes ❑ No

6.0 Prostate cancer

Have you ever been diagnosed with Prostate cancer?

❑ Yes ❑ No ❑ Not applicable

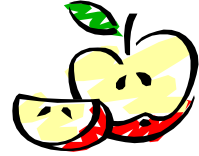
7.0 Do you have a family history of cancer?

❑ None ❑ 1 or less ❑ More than 1

8.0 Personal history of heart disease

Have you ever been diagnosed with any form of heart disease?

❑ Yes ❑ No



Section B
Personal Health History and Habits

9.0 Osteoporosis
Have you ever been diagnosed with or indicated that you were at risk for Osteoporosis?

❑ Yes ❑ No ❑ Not applicable

10.0 Colon/Rectal Screening
If you are over the age of 40, do you have an annual colon/rectal screening?

❑ Yes ❑ No ❑ Not Applicable

11.0 PAP Smear
If you are a female over the age of 18, do you have an annual PAP smear?

❑ Yes ❑ No ❑ Not Applicable

12.0 Mammogram Screening
If you are a female over the age of 35, have you had a mammogram within the past 2 years?

❑ Yes ❑ No ❑ Not applicable

13.0 Prostate screening
If you are a male over the age of 40, have you had a prostate screening within the past 2 years?

❑ Yes ❑ No ❑ Not applicable

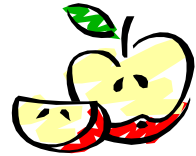
14.0 Routine Health Screening
How often do you see your physician for routine check-ups or health screenings?

❑ On an annual basis ❑ At least every 2 years
❑ Not within the past 5 years ❑ Never

15.0 Cancer Warning Signs
Indicate if you have any of the following cancer warning signs.

❑ Change in bowel or bladder habits
❑ Chronic indigestion or difficulty in swallowing
❑ Thickening or lump in breast or elsewhere
❑ Unusual bleeding or discharge, a sore that does not heal
❑ Change in freckle or mole

- ❑ Persistent cough or sore throat
- ❑ Unexplained weight loss
- ❑ None



Section C
Alcohol/Caffeine/Tobacco Consumption

16.0 Consumption of alcohol

How often do you consume alcohol?

- ❑ Never drink
- ❑ 2 days or less per week
- ❑ 3 days per week
- ❑ 4 or more days per week

17.0 Number of alcoholic beverages

On the days you drink, on the average how many drinks do you have?

- ❑ Never drink
- ❑ 1 to 2 drinks
- ❑ 3 to 4 drinks
- ❑ 5 or more drinks

18.0 Caffeine

How often do you consume caffeine in your diet including coffee, tea, cola or chocolate?

- ❑ Never
- ❑ Occasionally but not every day
- ❑ 1 to 3 servings daily
- ❑ 3 to 5 servings daily
- ❑ More than 5 servings daily

19.0 Smoking status

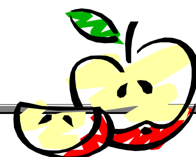
Indicate which of the following best represents your current status
NOTE: Check all that apply.

- ❑ Have never smoked
- ❑ Quit smoking less than 5 years ago
- ❑ Quit smoking more than 5 years ago
- ❑ Smoke pipe or cigar
- ❑ Smoke less than 1 pack of cigarettes per day
- ❑ Smoke more than 1 pack of cigarettes per day

20.0 Smokeless Tobacco

Do you use smokeless tobacco?

- ❑ Yes
- ❑ No



Section D
Exercise Program

21.0 Exercise Frequency

On the average, how many days per week do you exercise?

- ❑ 3 or more days per week
- ❑ Less than 3 days per week
- ❑ No regular exercise program

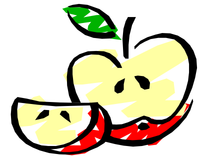
22.0 Proper stretching

Do you perform stretching prior to exercise?

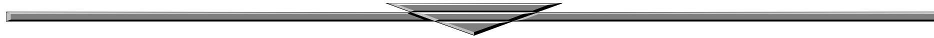
- ❑ Always
- ❑ Sometimes
- ❑ Never
- ❑ Currently not exercising

23.0 Warm-up and cool down

Do you warm-up and cool-down after exercising?



- ❑ Always
- ❑ Sometimes
- ❑ Never
- ❑ Currently not exercising



Section E

Nutrition Habits

24.0 Daily Meals

On the average how many meals do you consume per day?

- ❑ 3 meals with "healthy" snacks
- ❑ 3 meals
- ❑ 2 meals or less
- ❑ No regular eating pattern

25.0 Consumption of grain/bread products

On the average, indicate the type and amount of grain products you normally consume per day.
NOTE: A serving is 1 sl. bread, 1/3 cup beans / peas, 1/3 cup oatmeal, rice or other grain products.

- ❑ Whole grains at least 6 to 11 servings per day
- ❑ Whole grains 6 servings or fewer servings per day
- ❑ Refined grains such as white bread/rolls/processed flour at least 6 to 11 servings per day
- ❑ Refined grains such as white bread/rolls/processed flour 6 or less servings per day
- ❑ Rarely consume grain products

26.0 Consumption of vegetables

On the average, how many servings of vegetables do you consume per day? Note: A serving is approximately 1 cup of raw or 1/2 cup of cooked.

- ❑ At least 3 to 5 servings per day
- ❑ Less than 3 servings per day
- ❑ Rarely consume vegetables

27.0 Consumption of fruits

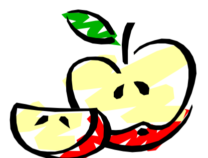
On the average, how many servings of fruit do you consume per day? Note: A serving is approximately 1 piece of fruit.

- ❑ At least 2 to 4 servings per day
- ❑ Less than 2 servings
- ❑ Hardly ever consume fruit

28.0 Daily consumption of dairy products

On the average, how many servings of dairy products do you consume per day? Note: A serving is approximately 1 cup of milk or 1 oz. of cheese.

- ❑ At least 2 servings per day
- ❑ Less than 2 servings
- ❑ Hardly ever consume dairy products



29.0 Type of Dairy products

Indicate the type of dairy products you consume.

- ❑ Nonfat selections only
- ❑ Both low fat and nonfat about the same
- ❑ Low fat only
- ❑ Usually high fat selections
- ❑ Do not consume dairy products

30.0 Daily consumption of meats and meat products

Indicate the type of meat you normally consume.

- ❑ Do not consume meat or meat products
- ❑ Consume less than 6 oz. of poultry or fish per day
- ❑ Consume more than 6 oz. of poultry or fish per day
- ❑ Consume less than 6 oz. of red meat per day
- ❑ Consume more than 6 oz. of red meat per day

31.0 Consumption of fats, dressings and spreads

Indicate the type and number of servings of fat, dressings and spreads you consume each day.
High fat examples: Butter, lard, and margarine
Low fat examples: Non-fat or Low-fat salad dressing-mayonnaise-cheese
SERVING SIZE: 1 Tablespoon

- ❑ Use low fat selections sparingly (less than 3 per day)
- ❑ Use low fat selections frequently (3 or more per day)
- ❑ Use both low fat and high fat about the same sparingly (3 or less)
- ❑ Use high fat selections sparingly (less than 3 per day)
- ❑ Use high fat selections (more than 3 per day)

32.0 Consumption of water

On the average, how many glasses of water do you consume per day? Note: A serving is one 8-oz. glass of water only; do not include coffee, soda or other beverages.

- ❑ At least 8 glasses per day
- ❑ About 4 to 8 glasses per day
- ❑ Less than 4 glasses per day
- ❑ Seldom consume water

33.0 Convenience and snack food consumption

On the average how many times per day do you eat convenience foods or forms of fast food?

- ❑ Never
- ❑ Less than 1 time per day
- ❑ More than 1 time per day

Section F
Personal Health

34.0 Dental Check-up

Do you have an annual check-up with your Dentist?

❑ Yes ❑ No

35.0 Oral Health

Do you have any abnormal bleeding in your gums or around your teeth?

❑ Yes ❑ No

36.0 Eye Examination

How often do you see an eye specialist?

❑ Once per year ❑ Once every two years
❑ Not within the last 2 years ❑ No regular exams

37.0 Cataracts

Have you ever been diagnosed with cataracts or other diseases of the eye?

❑ Yes ❑ No

38.0 Living Environment

Do you live or work in an environment, which you consider to expose you to pollution, either air, water or from your food?

❑ Yes ❑ No

39.0 Smoke Detector

Do you have at least one (working smoke detector for each floor of your home or apartment, which you check on a monthly basis?

❑ Yes ❑ No

40.0 Seat Belt Use

How often do you use your seat belt when either operating a motor vehicle or riding as a passenger?

❑ Always ❑ Sometimes ❑ Never

41.0 Automobile Mileage

How many miles per month do you drive an automobile or ride as a passenger?

❑ Less than 1000
❑ Between 1001 to 1499
❑ More than 1500 per month

42.0 Automobile Maintenance

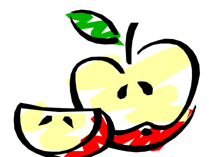
If you own an automobile, do you have regular maintenance performed such as checking the tires, oil etc.?

❑ Not applicable
❑ Yes
❑ No

43.0 Fire Protection

Do you have a working fire extinguisher in your home?

❑ Yes ❑ No



Section G
Health & Weight Management

4Have you ever used nutritional supplements?

❑ Yes ❑ No

4What type of nutrition supplements have you taken?

❑ Multi Vitamins ❑ Minerals
❑ Meal Replacements ❑ Anti-Oxidants
❑ Not Applicable
Other: ____

4Do you feel that excess body fat is effecting your health?

❑ Yes ❑ No

4How long do you feel that your weight has been a problem?

❑ Never overweight ❑ Fewer than 5 years
❑ 10 years or fewer ❑ 20 years or fewer
❑ More than 20 years

4How many times have you been on a diet or attempted to lose weight?

❑ Never attempted ❑ 1 to 4 times ❑ 5 or more times

49) On the average, how much weight do you lose when you diet?

❑ Never diet
❑ 5 or fewer pounds
❑ 10 or fewer pounds
❑ More than 10 pounds

50) Describe your attempts at weight loss

❑ Never attempted weight loss
❑ Caloric restriction alone
❑ Exercise alone
❑ Combination of diet and exercise

5Have you ever experienced any bulimic events?

- ❑ No
- ❑ Yes

5How many individuals in your direct family have a weight problem?

- ❑ None
- ❑ 2 or fewer
- ❑ More than 3

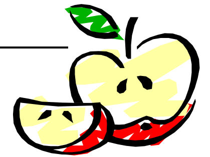
5Has your physician ever prescribed medication which was intended to help you lose weight?

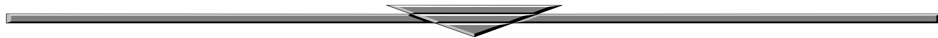
- ❑ Yes
- ❑ No

What medication (s)? ____

____

____





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LONGEVITY INDEX

Height	____________	Weight	____________
Impedance	____________	Body Fat	____________
Waist	____________	Hip	____________
Systolic Bp	____________	Diastolic Bp	____________
Heart Rate	____________		

LIPID PANEL

Cholesterol	____________	Triglycerides	____________
Hdl	____________		

CHEMISTRY PANEL

Glucose	____________	BUN	____________
Creatinine	____________	BUN/Creatine	____________
Sodium	____________	Potassium	____________
Chloride	____________	Albumin	____________
Total Protein	____________	Calcium	____________
Total Bili	____________	AAT	____________
ALT	____________	ALKP	____________
GGT	____________		

HEMATOLOGY

WBC	____________	LYP %	____________
Mono %	____________	GRA %	____________
Lymphocytes	____________	Monocytes	____________
Granulocytes	____________	RBC	____________
Hemoglobin	____________	Hematocrit	____________
MCV	____________	MCH	____________
MCHC	____________	RDW	____________
Platelets	____________	MPV	____________

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LONGEVITY INDEX

THYROID PANEL

TSH	___________	T-UPTAKE	___________
T4	___________	FTI	___________

OTHER TESTS

Homocysteine ___________

Lipid Peroxidase ___________

Hemoglobin A1C ___________

Facilitator notes ____

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Name ______________________________ Date ______________