

Medical Student Health & Nutritional Habits Questionnaire

Please take a couple of minutes to complete the following questions. Thanks for your cooperation.

| | None | 1-2 days | 3-5 days | >5 days |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| <i>How many times per week do you exercise?</i> | | | | |
| Cardiovascular (swim, bike, walk, jog, row, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight training (either isometrics or using wts.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stretching (on own, tai chi, yoga) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| <i>How many times per week do you practice meditation, prayer, or any other mind-body relaxation techniques?</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|

| | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| <i>At test time (at least the week before and test week) how many times per week do you practice the following?</i> | | | | |
| Cardiovascular exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight training | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stretching/Yoga/Tai Chi | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Prayer/Meditation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | | |
|---|---------------------------------------|--|--|--|-----------------------------------|
| <i>How much time do you spend on aerobic activities (swim, bike, walk, etc.) per session?</i> | 0-15 mins <input type="checkbox"/> | 20-30 mins <input type="checkbox"/> | 30-45 mins <input type="checkbox"/> | 45-60 mins <input type="checkbox"/> | >1 hr <input type="checkbox"/> |
|---|---------------------------------------|--|--|--|-----------------------------------|

| | | | | |
|--|---------------------------------|----------------------------------|----------------------------------|---------------------------------|
| <i>How many hours of sleep do you get on average per night?</i> | <input type="checkbox"/> <4 hrs | <input type="checkbox"/> 5-6 hrs | <input type="checkbox"/> 7-8 hrs | <input type="checkbox"/> >8 hrs |
| <i>What about during test time (the week before and during test week)?</i> | <input type="checkbox"/> <4 hrs | <input type="checkbox"/> 5-6 hrs | <input type="checkbox"/> 7-8 hrs | <input type="checkbox"/> >8 hrs |

| | | | | |
|--|-------------------------------|------------------------------|------------------------------|-----------------------------|
| <i>Do you eat out more during test time?</i> | Times Per Week | | | |
| | <input type="checkbox"/> None | <input type="checkbox"/> 1-3 | <input type="checkbox"/> 4-5 | <input type="checkbox"/> >5 |

| | | | | |
|--|-------------------------------|------------------------------|------------------------------|------------------------------------|
| <i>How many caffeinated beverages (soda, coffee, tea) do you consume on average per day?</i> | Per Day | | | |
| | <input type="checkbox"/> None | <input type="checkbox"/> 1-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 6 or more |

| | | | | |
|--|-------------------------------|------------------------------|------------------------------|------------------------------------|
| <i>How many glasses of water do you drink per day?</i> | <input type="checkbox"/> None | <input type="checkbox"/> 1-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 6 or more |
|--|-------------------------------|------------------------------|------------------------------|------------------------------------|

| | | | | |
|--|-------------------------------|------------------------------|------------------------------|------------------------------|
| <i>How many servings of fruits and vegetables do you eat on most days?</i> | <input type="checkbox"/> None | <input type="checkbox"/> 1-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 7-9 |
|--|-------------------------------|------------------------------|------------------------------|------------------------------|

What 3 things would you like to change about your health habits and how?

1. _____
2. _____
3. _____