

# Medical and Nutrition History Form

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Name \_\_\_\_\_ Date \_\_\_\_\_ Marital Status \_\_\_\_\_ Age \_\_\_\_\_

Reason for today's  
visit \_\_\_\_\_

# of people living in your household \_\_\_\_\_ # of children \_\_\_\_\_

**Check off any Health issues that apply:**

Diabetes	Irritable Bowel Syndrome	Polycystic Ovarian Disease
Renal Disease	Diverticulosis	Food Allergies
Heart Disease	GERD/Reflux	Stress
High Cholesterol/TG	Chronic Headaches/Migraines	Constipation
High Blood Pressure	Thyroid Disease	Crohn's Disease
Cancer	Overweight/Obesity	Colitis
Sleep Apnea	Eating Disorder	Celiac Disease

**Other Health Issues Not Mentioned Above:**

\_\_\_\_\_

**FAMILY HISTORY of above conditions**

\_\_\_\_\_

**Current Medications**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Vitamin/Mineral/Herbal Supplements**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Recent Lab Data - if available

Cholesterol \_\_\_\_\_ LDL \_\_\_\_\_ HDL \_\_\_\_\_ TG \_\_\_\_\_

Fasting Blood Sugar \_\_\_\_\_ HemoglobinA1c \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Nutrition and Exercise Habits

Height \_\_\_\_\_ Weight \_\_\_\_\_ Desired Weight \_\_\_\_\_ BMI ( \_\_\_\_\_ ) leave  
blank

Highest Adult Weight \_\_\_\_\_ Lowest Adult Weight \_\_\_\_\_

Have you lost or gained weight recently? YES \_\_\_\_ NO \_\_\_\_

If yes, explain

\_\_\_\_\_

Do you smoke \_\_\_\_\_ If yes, How much?

\_\_\_\_\_

How much alcohol do you drink/day \_\_\_\_\_ per/week

\_\_\_\_\_

Do you have any religious/cultural factors affecting your diet?

\_\_\_\_\_

What is your previous diet experience?

\_\_\_\_\_

Who is responsible for the food purchase \_\_\_\_\_ the preparation

\_\_\_\_\_

How many times do you eat out per week

\_\_\_\_\_

How many home cooked meals do you eat at home per week \_\_\_\_\_ Take out

\_\_\_\_\_

Do you exercise \_\_\_\_\_ How often and for how long

\_\_\_\_\_

What types of exercise do you do

\_\_\_\_\_

On a scale of 1 to 10 how motivated are you to change your diet or to lose weight?

\_\_\_\_\_ Using the same scale how confident are you? \_\_\_\_\_

What food do you like?

\_\_\_\_\_

What food do you dislike?

\_\_\_\_\_

**Food Recall: What have you eaten in the last 24 Hours? Or On a Typical Days Intake.**

Breakfast	Snack	Lunch	Snack	Dinner	Snack