NUTRITION/ MEDICAL HISTORY RECORD

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NAME:

Last First Middle Initial

STREET: CITY:

STATE: ZIP CODE:

HOME PHONE: CELL: WORK:

OCCUPATION:

LIST FAMILY MEMBERS:

MARITAL STATUS: MARRIED_____ SINGLE_____ DIVORCED_____ WIDOWED_____

BIRTH DATE: / / AGE: HEIGHT(no shoes): SEX: M__ F__

WEIGHT HISTORY: YOUR MAXIMUM WEIGHT (non pregnant): WEIGHT AT AGE 20: WEIGHT 1 YEAR AGO:

PRESENT WEIGHT: DESIRED WEIGHT:

ATHlETIC ACTIVITIES/ EXERCISE:

MEDICAL HISTORY:

HISTORY OF MENTAL ILLNESS and/or PSYCHOLOGICAL COUNSELING:

IMMEDIATE FAMILY HISTORY: DIABETES____ GOUT____ HEART TROUBLE___ HIGH B.P.___ STROKE___ OTHER_____

DESCRIPTION OF ANY MEDICAL PROBLEMS:

DAILY MEDICATIONS:

NAME	AMOUNT	REASON	DURATION

NUTRITIONAL HISTORY - SUPPLEMENTS: (including vitamins, minerals, herbs, fiber supplements, etc)

NAME	AMOUNT	REASON	DURATION

PREVIOUS DIETS YOU HAVE FOLLOWED:

TYPE	DATES/ LENGTH OF TIME STAYED ON	RESULTS

HAVE YOU HAD SURGERY FOR OBESITY IN THE PAST (give date):

ARE YOU CONSIDERING IT NOW:

FOOD ALLERGIES/ INTOLERANCES:

REASON FOR VISIT TODAY (GOALS):

HOW OFTEN DO YOU EAT OUT PER WEEK (include take-out meals): LUNCH: DINNER:

BREAKFAST: FAST FOOD MEALS PER WEEK:

DO YOU DRINK ALCOHOL: WHAT: HOW MUCH: (circle) WEEK or DAY

CHECK YOUR USUAL ENERGY LEVEL AT EACH TIME:

A.M.: GOOD___ FAIR___ POOR___ MID DAY: GOOD___ FAIR___ POOR___ P.M.: GOOD___ FAIR___ POOR___

FOODS YOU CRAVE/ WHAT TIME: