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MEDICAL HISTORY

Name:_____ **Date:**_____
Address:_____ **Age:**_____ **D.O.B:**_____
Town:_____**Zip:**_____ **Occupation:**_____
Sex:_____
Phone (home):_____ **Mobile:**_____
Office:_____
Education (circle the highest): ☐ **High school** ☐ **College** ☐ **Graduate Degree**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Living With: ☐ **Family** ☐ **Friends** ☐ **Alone** **# of Persons in Household** _____

 # Of Children in Household:_____ **Ages of Children:**_____

Primary Care Physician:_____
Address: _____
_____
Date of Last Medical Check-up:_____ **Last Date Blood Work Was Drawn**_____

Past Hospitalizations: _____ ☐ _____
Height:_____ **Weight:** _____ **Usual Weight:**_____

What do you want your ideal weight to be? _____

Family Medical History: (Ex: Diabetes, Cardiac, Cancer) _____
_____
_____
Do you have bowls movements daily? _____ **How many a week?**_____

Personal Medical History: Check problems you have or that have been diagnosed by a physician or other health professional.

- ☐ **Alcohol/ Substance Abuse**
- ☐ **Anemia**
- ☐ **Food Sensitivity**
- ☐ **Lactose Intolerance**
- ☐ **Other Allergies**
- ☐ **Arthritis**
- ☐ **Cancer**
- ☐ **Diabetes**
- ☐ **Heart Attack or Stroke**
- ☐ **High Blood Pressure**
- ☐ **Hypercholesterolemia**
- ☐ **Chewing Difficulties**
- ☐ **Gallbladder Disorder**
- ☐ **Gout**
- ☐ **Gastrointestinal Trouble**
- ☐ **Constipation**
- ☐ **Frequent Diarrhea**
- ☐ **Obesity**
- ☐ **Eating Disorder**
- ☐ **Sleeping Problems**
- ☐ **Ulcer**
- ☐ **Limitations on Activity**
- ☐ **Seeing, hearing, or other impairments:** _____
- ☐ **Other:**____

Medications (Include nonprescription drugs, aspirin, laxatives, antacids, oral contraceptives, estrogen):_____
Vitamins/Herbs (Strength/Amt):_____
Smoker? ☐**Yes** ☐**No** **If yes how many packs per day?**_____
Regular Exercise (List activities and times per week): _____
_____
Stress Level: Self-Assessment of stress level: ☐ **High** ☐**Moderate** ☐**Low**
Personality Type: ☐**Impatient, time oriented, competitive**
☐**Usually somewhat relaxed, sometimes anxious**
☐**Relaxed, easy going**
Severe Personal Problems in the past 12 months (Such as death of a family member, marital problems, job change, lawsuits, serious family issues, etc.):_____
Why are you visiting a nutritionist today?_____
_____
_____
If you are seeing the nutritionist for weight loss answer the following questions:
What is your typical challenge when starting or following through on a weight loss plan?_____
_____
_____
Have you ever been on a weight loss plan before? ☐**Yes** ☐**No** **Last 2 diets**_____
Date:_____ **If yes how much weight did you loose?**_____
How long was the weight maintained?_____ **What is most important to you regarding weight loss, what do you want to achieve being a thinner person or why do you want to be thinner?**_____
_____

Meal Plan History? What did you eat yesterday? List Water/Coffee/Tea/Diet Coke
Do you drink Water/Coffee/Tea/Diet Coke in between meals?_____
Please Note Beverage amounts: _____

Breakfast:	**Snack:**	**Beverages:**	**Other:**
Lunch:	**Snack:**	**Beverages:**	**Other:**
Dinner:	**Snack:**	**Beverages:**	**Other:**