Bonnie R. Giller, MS, RD, CDN, CDE
Certified Diabetes Educator

Reason for Consult ______________________ Date ____________________

MEDICAL HISTORY

Name ____ Sex ____________ Age_____________
Address____ Date of Birth_____________________
____ Phone (home)____________________
Email ____ (work)_____________________
(cell)______________________

1. Occupation ____ Ethnic group:_____________________

2. Education (circle highest): high school college: 1 2 3 4 graduate degree

3. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

4. Living with: ☐ Family ☐ Friends ☐ Alone
Number of Persons In Household _______ Number of children in Household________
Ages of Children________________________

5. Primary care Physician ______________________________

Address ____ Phone_________________________
____

Date of last checkup_______________________

Past hospitalizations:____
____

6. Family Medical History: Check items that apply for your blood relatives, including children, brothers, sisters, parents, and grandparents.

- ☐ Alcohol/Substance Abuse
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression/mental illness
- ☐ Food sensitivity
- ☐ Stroke
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Obesity
- ☐ Smoking
- ☐ Thyroid dysfunction

Are your parents living?______________

If not, at what age did she or he die? Mother _____ Father______

7. Personal Medical History: Check problems you have or had 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
- ☐ Hyperlipidemia
- ☐ Chewing difficulties
- ☐ Gallbladder disorder
- ☐ Gout
- ☐ Gastrointestinal trouble
- ☐ Constipation
- ☐ Frequent Diarrhea
- ☐ Obesity
- ☐ Eating disorder
- ☐ Sleeping problems
- ☐ Ulcer
- ☐ Limitations on activity
- ☐ Other: _______________ _____________________

Seeing, hearing, other impairment:_____________________________________

8. Medications (include nonprescription drugs, aspirin, laxatives, antacids, oral contraceptives, estrogen, vitamins and herbs):____

____

____

9. Smoking:

- ☐ Smoke cigarettes
- ☐ Smoke pipe/cigar
- ☐ Quit smoking in past year
- ☐ Nonsmoker

cigarettes per day_________

10. Regular Exercise (including on the job):

☐ Yes ☐ No

times per week ______________

minutes per session __________

Describe:____

____

____

Limitations on Activity:

Describe____

____

____

11. Have you ever been seen by a Dietitian/Nutritionist? ☐ Yes ☐ No

If Yes: Who? ____ When? ___________________________

Why? ____

12. Height ___________________

Highest Adult Weight ________________

Lowest Adult Weight ________________

13. List any nutrition goals you hope to achieve as a result of nutrition counseling:

____

____

____

____

14. Stress Level:

Self-assessment of stress level: ☐ high ☐ moderate ☐ low

15. Personality type:

- ☐ impatient, time-oriented, competitive
- ☐ usually somewhat relaxed, sometimes anxious
- ☐ relaxed, easy going

16. Severe personal problems in the past 12 months: (such as death of family member, marital problems, divorce, job change, accidents, lawsuits, serious family problems, ill health):

____

____

____

17. Relaxation techniques practiced: ☐ yes ☐ no

If yes, describe: ____

____

____