

Reason for Consult _____

Date _____

MEDICAL HISTORY

Name _____

Sex _____ Age _____

Address _____

Date of Birth _____

Email _____

Phone (home) _____

(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 _____

How many siblings do you have? _____

Please list their age(s) _____

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 _____

Recent weight loss or gain? Explain: _____

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: _____

