Name Date

Marital Status Age

Reason for today’s visit

Number of people living in your household Number 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, please explain

Do you smoke? Yes No

If yes, How much

How much alcohol do you drink per/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? Yes No

If yes, 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** |
|  |  |  |  |  |  |