

NUTRITION RELATED HISTORY

Patient Name: _____ **Date:** ____/____/____

Age: _____ Date of Birth: ____/____/____ Sex: M F Ethnicity: _____

Phone Number: _____ Referring Clinician: _____

Reason for Visit: _____

Personal Goal(s) with Nutrition: _____

Recent weight change (gain/loss in what time frame): _____

Possible Reason for Weight Change: _____

Current Exercise Schedule: _____

Disabilities: _____

Appetite: Excellent Good Fair Poor Dentures: Yes No

Difficulty swallowing/chewing? (if yes, describe): _____

Recent nausea, vomiting, constipation, diarrhea: (if yes, describe): _____

Cultural or religious food preferences: _____

Motivation level for change: No motivation 1 2 3 4 5 Very Motivated

Have you seen a dietitian before? If so for what?: _____

Past Medical History: (check off all current (C) or resolved (R) conditions)

C <input type="checkbox"/> R <input type="checkbox"/> High Cholesterol	C <input type="checkbox"/> R <input type="checkbox"/> Pre-Diabetes	C <input type="checkbox"/> R <input type="checkbox"/> Gastrointestinal Disorders (IBS, Celiac Disease, GERD, Gastric Bypass etc.)
C <input type="checkbox"/> R <input type="checkbox"/> High Triglycerides	C <input type="checkbox"/> R <input type="checkbox"/> Diabetes	If so, describe: _____
C <input type="checkbox"/> R <input type="checkbox"/> High Blood Pressure	C <input type="checkbox"/> R <input type="checkbox"/> Cancer	_____
C <input type="checkbox"/> R <input type="checkbox"/> Overweight/Obesity	C <input type="checkbox"/> R <input type="checkbox"/> Underweight	C <input type="checkbox"/> R <input type="checkbox"/> Other: _____

Lifestyle: Employed? Yes No Occupation: _____

Sources of stress: _____

Work schedule: _____

Barriers to eating healthy when at work: _____

Barriers to eating healthy when at home: _____

Barriers to eating healthy on the weekends: _____

Please start thinking about how you eat on a regular basis before you come in for the consult. Thank you!