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Health &Nutrition History

Date of Assessment: _____

Patient Name: _____ DOB: _____ Age: _____

Address: _____

Phone: _____ Email: _____ Insurance:_____

Status of your Health: _____ Sex: M F

Current Medical Conditions/Diagnoses: _____

Do you take any of the following:

Vitamins and or Mineral Supplements? _____

Herbal Supplements? _____

Prescription Medications? _____

Over-the counter Medications? _____

Height: _____ Weight: _____ BMI: _____ Frame: _____ DBWR: _____

Usual Body Weight: _____ Recent Weight Changes: _____ Time Frame: _____

Total Cholesterol: _____ LDL's: _____ HDL's: _____ TG's: _____

Food Intolerances or Allergies? _____ GI Problems? _____

Difficulty Chewing or Swallowing? _____ Constipation? _____

Exercise: _____ Frequency: _____

Who does the shopping? _____ Cooking? _____

Number of meals eaten away from home per week? _____

Usual Daily Food Intake:

Breakfast: AM Snack: Lunch: PM Snack: Dinner: HS Snack: