PATIENT PERSONAL/NUTRITION & HEALTH HISTORY (RP)

Name:_____ Date:_____

Address:_____ City:_____ St:____ Zip:_____

Phone: (H) _____ (W) _____ (Cell) _____

Email: _____ Age: _____ Birth Date: _____

Marital Status: Married __ Single __ Widower __ Divorced __

Name of Spouse or significant other:_____

What is your profession? _____ or Skills _____

Highest level of education: 6th grade __ 12th grade __ Tech/Voc __ College __ Other _____

Do you speak/read English? Yes___ No ___If no, what language do you speak?_____

Primary Care Provider _____ Phone _____

How often do you visit your Primary Care Provider _____

What is your best way of learning (check all) Lecture __ Audio __ Visual__ Other _____

Do you smoke? Yes__ No __ Quit (date _____) How many in a typical day? _____

Do you drink alcohol? Yes __ No __ 4-8 ozs ___1days/wk __2-3 days/wk ___ Other_____

What is your height? _____ present weight? _____ waist? _____ hip? _____

Are you concerned about your weight? ___ Do you need to Gain?____ Lose? _____

What is your goal weight? _____ pounds; highest adult weight? _____ pounds

What was you lowest adult weight? _____ Age at this weight? _____

What is your vision for your health?_____

What do you think is preventing you from achievement that vision?

_____

How strong is your commitment to your vision? ON A SCALE FROM 1-10? _____

Do you exercise? Yes ___ No. If yes, what type? Please explain what you do and how often

_____ _____

Have you been on any fad diets before? _____ No _____ Yes. If yes, names_____

What lifestyle changes are you willing to make? _____

Describe your present lifestyle (check all or fill that apply)

a) My family eats home cooked meals _____ days a week

b) I plan my meals in advance ___ times a week

c) I eat fast foods _____days a week; Grocery shopping _____ days a week

Do you follow a meal plan? _____ Yes ___ No. If yes please describe _____

_____

List below the time of day you eat and what you eat in a normal day. (include all fluids).

	Morning	Snack	Lunch	Snack	Dinner	Snack(s)
Time:						
Food:						

List at lease two (2) of your favorites in each food group

Fruits	Vegetables	Grains	Protein	Dairy	Fat/Oils

Have you ever experience low blood sugar reaction? _____Yes _____No.

If yes, what were your symptoms and how do you treat it? _____

_____

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If yes, what were your symptoms and how do you treat it? _____

_____

Do you take any supplements? Names_____

Do you take medication? __No; ___Yes. If yes, please list them on the next page with your conditions and symptoms.

Please answer if at any period in your life you were told you had any of these conditions?

Condition	Yes/No	Month/Year	Symptoms	Treatment
High Blood Pressure/ Hypertension				
Gestational Diabetes				
Pre-Diabetes				
Type 2 Diabetes				
Type 1 Diabetes				
High Cholesterol				
Kidney Disease				
Liver Disease				
Asthma				
Allergies Type:				
Acid Reflux				
Hiatal Hernia				
Heart Disease				
Arthritis				
Digestive Problems (e.g. constipation, acid reflux, heart burn etc…				
Heart Problems				
Vision Problems				
Any other concerns not listed:				

What is your greatest fear about your present lifestyle if you do not attempt to do something about it?

_____

_____