DOWNTOWN DIETITIAN

Reason for Consult _____ Date _____

MEDICAL HISTORY

Name _____ Sex _____ Age _____

Address _____ Date of Birth _____

_____ Phone (home) _____

Email _____ (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 _____

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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 _____

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: _____
_____
_____