WESTON
MED SPA & COSMETIC SURGERY

THE TEMPLE

NUTRITION ASSESSMENT FORM

One's health and well-being are influenced by many different things, including lifestyle, family history, emotional health, and nutrition/eating habits. Please complete the following questionnaire to the best of your ability to give us an overall view of your general lifestyle and health habits.

Name *(Last, First, M.I.):* ☐ M ☐ F ☐ NB	**DOB:**
Occupation:	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed		
Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.			
Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet (Previous)	Have you diet before? ☐ Yes ☐ No What kind of diet have you tried before?: Did it work? ☐ Yes ☐ No (Explain) _____ Did you use supplement(s)? ☐ Yes (Which type? _____)☐ No Have you tried appetite suppressors? ☐ Yes (Which type? _____)☐ No	Duration:	
Diet (Current)	Are you dieting?	☐ Yes	☐ No
	If yes, are you on a prescribed medical diet?	☐ Yes	☐ No
	# of meals you eat in an average day?		
	What is the schedule for your meals? (Write an example day routine)		

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	Do you cook : ☐ Yourself ☐ Mostly Familiar ☐ Eat Outside ☐ Mostly do fasting (*Hours __)			
	Rank salt intake	☐ Standard with Food	☐ I add more	☐ I avoid salt
	Rank fat intake	☐ I eat mostly fried	☐ Avoid fried food	☐
Fat Types	☐ Vegetable Oil	☐ Olive Oil	☐ Coconut	☐ Other
Common allergies	Gluten ☐	Peanut ☐	Eggs ☐	Fish☐
	Tree Nuts ☐	Dairy ☐	Soy ☐	Shellfish ☐
Other exclusions				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			☐ Yes ☐ No
	If yes, what kind?			
	How many drinks per week?			
Tobacco	Do you use tobacco?			☐ Yes ☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?			☐ Yes ☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes ☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

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WOMEN ONLY

Date of last menstruation:		
Period every _____ days		
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No

MEN ONLY

Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Date of last prostate and rectal exam? (If you are older than 50 years old)	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Please fill this form and e-mail to lissette@thetemple.health or lissetteporras@gmail.com