Functional Gut

New Patient Information Form

Reason for Consult _____ Date _____

MEDICAL HISTORY

Name_____ Sex_____Age_____
Address_____ Date of Birth_____
_____ Phone (1º)_____
Email _____ (2º)_____

1. Occupation _____

2. Education (circle highest): high school TAFE university: undergrad postgrad

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 GP _____

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 recreational 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? _____

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12. Height _____

Highest Adult Weight _____

Lowest Adult Weight _____

Recent weight loss or gain? Explain: _____

_____

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: _____

_____

_____