HEALTH HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

Name _____

Address _____

_____

Phone # _____ (Cell) _____

Social Security # _____

Email_____

DOB ___ / ___ / _____ Age _____ Gender: M F

Marital status: M S D W Ethnicity _____

Number of children: _____

Employment status: Fulltime Part-time Retired Disability

Occupation: _____

Place of Employment:_____

PHYSICIAN INFORMATION

Name _____

Address _____

_____

Phone # _____

Height: _____ **Weight:** _____

Usual Weight:_____ **Goal Weight:_____**

Reason for Appointment:_____

_____

How did you hear of Nutrition Solutions?

_____

What are your goals: *(Please indicate all that apply)*

Lose weight	Improve muscle conditioning
Improve nutrition	Reduce stress
Lower cholesterol	Improved health
Improve cardio. fitness	Feel better overall

Other (please specify): _____

Have you ever been advised by your physician to follow a special diet? Yes No

If Yes, please specify:_____

Are you currently following that diet?

Yes No

If Applicable:

Have you tried other weight loss programs in the past?

Yes No

If *YES*, please specify:_____

_____

Compared to previous attempts, how motivated are you to lose weight at this time?

1. Not at all motivated
2. Slightly motivated
3. Somewhat motivated
4. Quite motivated
5. Extremely motivated

How certain are you that you will stay committed to a weight-loss program for the time it will take to reach your goal?

1. Not at all certain
2. Slightly certain
3. SOMEWHAT CERTAIN
4. Quite certain
5. Extremely certain

Do you eat more than you would like to when you have negative feelings, such as anxiety, depression, anger, or loneliness?

1. Never
2. Rarely
3. Occasionally
4. Frequently
5. Always

Are there any foods that often cause you to overeat?

Yes No

If *YES*, please list: _____

_____

Are you presently trying to make any other big changes in your life (e.g., divorce, job change, moving, smoking cessation?)

Yes No

If *YES*, please list: _____

Check the description that best represents the amount of stress you experience on a daily basis.

No stress	Frequent moderate stress
Occasional mild stress	Frequent high stress
	Constant stress

HEALTH HISTORY QUESTIONNAIRE

Do you drink alcoholic beverages at all?

Yes No

If *YES*, please specify the number of drinks *per week*:

0-2 drinks 3-14 drinks More than 14 drinks

NOTE: One drink equals one ounce of hard liquor, 6 oz. of wine, or 12 oz. of beer.

Specify type:_____

Are you presently exercising a minimum of three times per week at least 30 minutes at a time?

Yes No

If *YES*, please specify:

Running/jogging Brisk walking Biking

Aerobic dancing Racquet sports Swimming

Weight training Cross country skiing

Other *(please specify):* _____

Total *minutes* engaged in aerobic activity *per week*:

0-20 min/week 21-40 min/week 41-60 min/week

61-80 min/week 81-100 min/week 100+ min/week

Do you belong to a gym? Yes No

Do you have any equipment in the home?

Yes No

If yes, please specify:_____

_____

Have you participated in cardiac rehabilitation or physical therapy in the past 12 months? Yes No

If *YES*, for what reason? _____

Family Weight History:

Are any members of your family overweight?

YES NO

Does your family eat meals together?

Yes No

Does anyone in your family diet?

Yes No

If yes, please explain_____

_____

Do any of the following apply to your immediate family?

Heart attack / cardiac related surgery prior to 50 years of age

Strokes prior to 50 years of age

If so, please specify:_____

_____

EATING HABITS:

Who does the grocery shopping?_____

Who usually prepares the food at home?_____

Do you know how to cook? Yes No

Do you eat standing up? Yes No

Do you eat fast? Yes No

Do you eat while watching TV? Yes No

Do you eat while in the car? Yes No

Do you avoid certain foods? Yes No

If yes, please specify_____

_____

What are your expectations from coming to see the dietitian today?

_____

_____

HEALTH HISTORY QUESTIONNAIRE

Check all that apply.

- Last physician office visit greater than 1 year ago
- Congenital heart disease
- Heart failure
- Heart disease
- Palpitations or tachycardia
- Pacemaker or IACD
- Heart attack
- Bypass or other cardiac surgery / procedures
- Currently taking medication for heart condition
- Chest discomfort with or without activity
- Diagnosed uncontrolled hypertension (above 140/90)
- Experience frequent light headedness or fainting
- Epilepsy or seizures
- Head trauma
- Sleep apnea
- Shortness of breath while performing normal activities
- Bone or joint condition aggravated by activity
- Currently pregnant or less than six weeks post-partum
- Eating disorder
- Hernia
- Cancer or lymphedema
- Stroke
- Current physical therapy (within past 3 months)
- Diabetes
- Impaired glucose tolerance
- Kidney disease
- Infectious mononucleosis (current)
- Physician currently restricting activity level

- Female over 55
- Male over 45
- Currently taking blood pressure medication
- Heart murmur
- Diagnosed hypercholesterolemia (above 240mg/dl)
- Emphysema
- Asthma
- Osteoporosis
- Foot problems
- Knee problems
- Back problems
- Shoulder problems
- Current smoker
- Do not currently exercise
- Currently 20 pounds over ideal weight

Check all that apply.

- Rheumatic fever
- Poor circulation
- Diagnosed controlled hypertension
- Low blood pressure
- Don't know resting blood pressure
- Don't know cholesterol
- Migraine/headaches
- Anemia
- Bronchitis
- Pneumonia
- Hyperthyroid / hypothyroid disorder
- Menopause
- Fibromyalgia
- Increased anxiety
- Depression
- Unusual fatigue
- Swollen or stiff joints
- Bursitis
- Broken bones
- Osteopenia
- Ulcer
- Stomach or intestinal problems
- Acid reflux
- Former smoker - quit less than 1 year ago
- Weight loss surgery

Are you currently being treated for any other medical condition(s)?

Yes No

If *YES*, please list:

_____

Please list any medications you are currently taking and the reason.

_____

_____

_____

Please list any vitamins / herbal supplements you are currently taking.

_____

_____

_____

Please list any allergies, including food allergies:

_____

Health Professional: _____ *Date:* _____