Medical and Nutrition History Form

Stacie Castle, MS, RD, CDN
(516) 652-2747

Name _____ **Date** _____ **Marital Status** _____ **Age** _____
Reason for today's visit_____
# of people living in your household _____ **# of children** _____

***Check off any Health issues that apply*:**

Diabetes	**Irritable Bowel Syndrome**	**Polycystic Ovarian Disease**
Renal Disease	**Diverticulosis**	**Food Allergies**
Heart Disease	**GERD/Reflux**	**Stress**
High Cholesterol/TG	**Chronic Headaches/Migraines**	**Constipation**
High Blood Pressure	**Thyroid Disease**	**Crohn's Disease**
Cancer	**Overweight/Obesity**	**Colitis**
Sleep Apnea	**Eating Disorder**	**Celiac Disease**

Other Health Issues Not Mentioned Above:
_____

FAMILY HISTORY of above conditions
_____

Current Medications
_____
_____
_____

Vitamin/Mineral/Herbal Supplements
_____
_____
_____

Recent Lab Data – if available

Cholesterol _____ **LDL** _____ **HDL** _____ **TG** _____
Fasting Blood Sugar _____ **HemoglobinA1c** _____ **Blood Pressure** _____

Nutrition and Exercise Habits

Height _____ **Weight** _____ **Desired Weight** _____ **BMI (_____) leave blank**
Highest Adult Weight _____ **Lowest Adult Weight** _____
Have you lost or gained weight recently? YES ____ **NO** _____
If yes, explain
_____
Do you smoke _____ **If yes, How much?**
_____
How much alcohol do you drink/day _____ **per/week**
_____

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Do you have any religious/cultural factors affecting your diet?

_____

What is your previous diet experience?

_____

Who is responsible for the food purchase _____ the preparation

_____

How many times do you eat out per week

_____

How many home cooked meals do you eat at home per week _____ Take out

_____

Do you exercise _____ How often and for how long

_____

What types of exercise do you do

_____

On a scale of 1 to 10 how motivated are you to change your diet or to lose weight?

_____

Using the same scale how confident are you? _____

What food do you like?

_____

What food do you dislike?

_____

Food Recall: What have you eaten in the last 24 Hours? Or On a Typical Days Intake.

Breakfast	Snack	Lunch	Snack	Dinner	Snack