Date:

HEALTH HISTORY

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
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

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

Allergies/Reaction to medications

Name the drug	Reaction you had

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HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf with cart)				
	☐ 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	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
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?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
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
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

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FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS INCLUDING OBESITY, EATING DISORDERS		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*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No

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The Nutrition Assessment

If referred by a physician, therapist, hospital or treatment center, obtain the following information prior to the client's first visit:

- Reason for referral: _____
  _____
- Goal of referral: _____
  _____
- Current status of _____
  _____
- Requested number of visits: _____

Medical Assessment

Attach referral or discharge notes or request information on the following:
Medical Evaluation:

___ Height
___ Weights
___ Laboratory values
___ Anthropometric
___ Bone density
___ Prior medical conditions
___ Prior sexual abuse history
___ Prior treatment history
___ Current medications
___ Food allergies or intolerances
___ Was a goal weight identified? ____ If yes, what is goal weight? _____
___ How was goal weight determined? _____
___ Has the client been under the care of a medical and/or mental health provider?

- For how long? _____ For what reasons?
  _____
  _____
  _____

Does the client currently have a regular menstrual period? _____

- Age of first menstruation: _____
- Use of birth control pills: _____

Notes:

_____
_____
_____
_____
_____

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PERSONAL AND FAMILY HISTORY

(if not available, obtain at first visit)

Current occupation or student status: _____

Ranking in occupation or as student: _____

Satisfaction in occupation or as student: _____

Marital status: _____

Satisfaction with marital status _____

If married, spouse occupation: _____
Number and ages of children:
Child 1: _____
Child 2: _____
Child 3: _____

How do you rate your capabilities as a mom?
____poor ____fair ____good ____great

If single, what is your living arrangement?
- ☐ Apartment on own
- ☐ Apartment with roommate
- ☐ Home with parent(s)
- ☐ Home with relative other than parent(s) housing and number in household

If parents are divorced, age of client at time of divorce: _____
If siblings, number and sex of siblings:
Sibling 1: _____
Sibling 2: _____
Sibling 3: _____

Is there anyone in the family with:
- ☐ weight problems
- ☐ an eating disorders
- ☐ any other illness (mental or physical) List: _____

_____

_____