





**CENTER FOR NUTRITION AND PREVENTIVE MEDICINE**

Today's date:		Referred by:		
Patient's Last name:	First:	Middle:	Date of birth: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		SSN: - -		
City:		State:	Zip:	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partner				
Home phone no.: ( )		Cell phone no.: ( )		Office phone no.: ( )
E-mail address:			Occupation:	
Preferred method of communication: <input type="checkbox"/> E-mail <input type="checkbox"/> Phone <input type="checkbox"/> Mail			Employer:	
Name of insured (if different from patient):			Date of birth of insured: / /	
Relationship to insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
Primary insurance: Plan name: ID no.:                      Group no.:		Type: <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HMO Copay: \$                      Deductible: \$		
Secondary insurance: Plan name: ID no.:                      Group no.:		Type: <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HMO Copay: \$                      Deductible: \$		
Demographic information: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic Preferred language:		Race (list more than one if applicable):		
Describe the problem or condition which prompted this visit:				
List any medications you are taking with their dosage and frequency:				
List any dietary supplements you are taking with their dosage and frequency:				
Do you have any allergies to medication or other substances? If so please list:				
List any operations and their dates:				
List any major or serious illnesses you have had (heart attack, diabetes, cancer, measles, etc.) and their dates:				
List any accidents or injuries and their dates:				
List number of pregnancies:		Births:	Last menstrual period:	
Date of last:    Pap smear:	Mammogram:	Chest X-ray:	Colonoscopy:	Bone density test: <input type="checkbox"/> Yes <input type="checkbox"/> No

If any family members have had the following disorders please list them below:				
Cancer	Type	Heart Disease (heart attack, stroke, etc.)	Diabetes	Obesity

Have you had: Flu vaccine?  Yes  No Date \_\_\_/\_\_\_/\_\_\_ Pneumonia vaccine?  Yes  No Date \_\_\_/\_\_\_/\_\_\_  
Tetanus vaccine?  Yes  No Date \_\_\_/\_\_\_/\_\_\_ Hepatitis B vaccine?  Yes  No Date(s) \_\_\_/\_\_\_/\_\_\_, \_\_\_/\_\_\_/\_\_\_, \_\_\_/\_\_\_/\_\_\_  
Do you smoke?  Yes  No How many packs / day? \_\_\_\_\_ For how many years? \_\_\_\_\_ Quit \_\_\_\_\_ years ago.  
Do you drink alcoholic beverages?  Yes  No What type? \_\_\_\_\_ How much daily? \_\_\_\_\_  
Do you drink coffee?  Yes  No Type? \_\_\_\_\_ # cups / day? \_\_\_\_\_  
Do you drink tea?  Yes  No Type? \_\_\_\_\_ # cups / day? \_\_\_\_\_  
Do you drink colas?  Yes  No Type? \_\_\_\_\_ # cups / day? \_\_\_\_\_  
Are you presently following any type of special diet?  Yes  No  
Please describe it: \_\_\_\_\_  
Are there any foods you cannot or will not eat?  Yes  No Please list them: \_\_\_\_\_

Do you exercise regularly?  Yes  No How many minutes daily? \_\_\_\_\_  
What activities do you engage in? \_\_\_\_\_

Classify your weight control:  No problem, can eat anything  
 Minor problem, amenable to self-control  
 Major problem, numerous diets, ups and downs

What diets have you tried, if any? \_\_\_\_\_

Minimum weight as an adult: \_\_\_\_\_ lbs. at age: \_\_\_\_\_ Maximum weight as an adult: \_\_\_\_\_ lbs. at age: \_\_\_\_\_

Have you had any of the following conditions or problems? (If yes, please check and circle as appropriate. Add any additional pertinent comments.)

<input type="checkbox"/>	Nearsighted, farsighted, presbyopia, cataracts	<input type="checkbox"/>	Abdominal pain
<input type="checkbox"/>	Glaucoma, trouble seeing at night	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Double vision	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Difficulty with hearing	<input type="checkbox"/>	Unusual bowel movements (bleeding, dark black, floating, greasy, etc., other)
<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	Liver disease (hepatitis: type A, B, C, jaundice)
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Gallbladder disease
<input type="checkbox"/>	Stuffed nose, allergies (What time of year? _____)	<input type="checkbox"/>	Ulcer, type: _____
<input type="checkbox"/>	Headaches, type _____ frequency _____	<input type="checkbox"/>	Other gastrointestinal disease
<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Kidney disease (infections, stones, bleeding, other)
<input type="checkbox"/>	Numbness, tingling, pins and needles sensation	<input type="checkbox"/>	Bladder or prostate problems (trouble urinating, slow, urination at night, (# times ___/night, burning)
<input type="checkbox"/>	Weakness, fatigue (how long? _____)	<input type="checkbox"/>	Blood disorders (anemia, prolonged bleeding, etc.)
<input type="checkbox"/>	Cardiovascular disease (heart attack, stroke, hypertension, angina, atherosclerosis, palpitations, arrhythmia, heart murmur, other)	<input type="checkbox"/>	Diabetes, type: _____ Year of onset _____
<input type="checkbox"/>	Difficulty breathing, coughing, wheezing	<input type="checkbox"/>	Thyroid disease Type _____
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Arthritis or gout (describe where) _____
<input type="checkbox"/>	Bronchitis, emphysema	<input type="checkbox"/>	Lipid disorder (high cholesterol, high triglycerides)
<input type="checkbox"/>	Trouble swallowing, painful swallowing	<input type="checkbox"/>	Sexually transmitted diseases: herpes, Chlamydia, gonorrhea, syphilis, HPV, HIV
<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Low sex drive, erection difficulty
<input type="checkbox"/>		<input type="checkbox"/>	PMS, menopausal symptoms, describe _____
<input type="checkbox"/>		<input type="checkbox"/>	

Do you have any other disease or condition not listed above that we should know about? Please list and explain: \_\_\_\_\_