Nutrition Health History Form

Name: _____ Date: _____

Best Phone Number to Reach You: _____ _____ E-mail Address: _____

Reason for Consultation: _____ ___

Referred By: _____

Age: _____ Gender (F/M): _____ Race: _____

Marital Status: _____ Children: _____ Profession: _____

Are you a member of Health Place? ☐ Yes ☐ No Are a WellStar employee? ☐ Yes ☐ No

Are you a direct family member of a Health Place member or WellStar employee? ☐ Yes ☐ No

Personal Medical History

Check off any conditions that you currently have or used to have:

☐ Diabetes Type: _____

☐ Heart disease

☐ Pregnant

☐ Osteoporosis

☐ Hypoglycemia

☐ Post-menopausal

☐ High blood pressure

☐ Stroke

☐ Eating disorder Type: _____

☐ Heart attack

☐ Cancer Type: _____

☐ Alcoholism

☐ Drug abuse

☐ Chronic constipation

☐ Sleep apnea

☐ Migraines

☐ Shortness of breath

☐ Thyroid disorder

☐ Food allergies/sensitivities Explain:

☐ Lactose intolerant

☐ Celiac disease

☐ Auto-immune disorder

Explain:

☐ Other

Explain: _____

List any recent surgeries: _____

List all medications: _____

_____

Do you take any vitamin, mineral, herbal or other dietary supplements?

☐ Yes List: _____

☐ No

Check off if you frequently experience any of the following:

☐ Diarrhea

☐ Constipation

☐ Bloating/gas

☐ Dry skin

☐ Heartburn/reflux

☐ Light-headed/dizzy

☐ Colds/flu

☐ Water retention

☐ Sinus problems

☐ Headaches

☐ Allergies

☐ Mood swings

☐ Muscle twitches

☐ Irregular periods (females only)

☐ Bleeding gums

☐ Easy bruising

☐ Canker sores

☐ Brittle nails

☐ Tingling in fingers/toes

☐ PMS

☐ Low immune system (frequent illnesses)

☐ Nausea

☐ Cracks on corners of lips

Family Medical History

Check all the conditions that a family member has had and indicate the family member:

☐ Diabetes Type: _____

☐ Heart disease

☐ Stroke

☐ High blood pressure

☐ Osteoporosis

☐ Thyroid disorder

☐ Heart attack

☐ Cancer Type: _____

☐ Alcoholism

☐ Drug abuse

☐ Celiac disease

☐ Other

Explain: _____

Do you smoke? ☐ Yes ☐ No If yes, how much (how often, how many)? _____

If yes, what type? _____ Do you want to quit? ☐ Yes ☐ No ☐ Unsure