nodSpecialists
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Timely Access to Specialty Physicians

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NUTRITION ASSESSMENT

Name: ________________________________

DATE OF BIRTH: _________________________ HEIGHT: _____ Ft. _____Inch

Occupation: ____________________________

Body Weight (if known): _________

How often do you weigh yourself? ☐ 1-3/day ☐ daily ☐ weekly ☐ monthly ☐ never

What do you consider your healthy weight? _________

Why? ____

What was your highest adult weight? Date: _______

What was your lowest adult weight? Date: _______

What prompted you to make an appointment to seek Medical Nutrition Therapy?

1.

2.

3.

What Are Your Goals for Medical Nutrition Therapy:

1.

2.

3.

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MEDICAL AND NUTRITION HISTORY

List Medical History:	
Do you have family history of diabetes? Do you have family history of heart disease?	☐ Yes ☐ No; If yes, list closest relatives ☐ Yes ☐ No; If yes, list closest relatives

Please list all medications you are currently taking:	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please list all the dietary supplements, vitamins/minerals, or herbs that you are currently taking (and dose):

1. What was the date of your last medical doctor's visit?	Date:
2. How often do you see your doctor?	☐ Weekly ☐ Monthly ☐ Annually
3. Have you had your bone density measured?	☐ No ☐ Yes date:________ Result: ☐ Normal ☐ Osteopenia ☐ Osteoporosis
4. Do you smoke cigarettes?	☐ Yes _____ packs/day ☐ No
5. Do you drink alcohol:	☐ Yes ☐ No How many servings per day:
6. Do you use recreational drugs?	☐ Yes ☐ No

7. Do you suffer from constipation?	☐ Yes ☐ No
8. Do you suffer from chronic diarrhea?	☐ Yes ☐ No
9. If you answered yes to either # 7 or 8, how do you manage these conditions?	
10. Do you restrict how much you eat?	☐ Yes ☐ No
11. Do you have a history of an eating disorder?	☐ Yes ☐ No
12. Do you follow a specific number of calories per day?	Calories:
13. Do you exercise or do activities regularly to maintain your health?	☐ Yes ☐ No; List types:
14. How often do you exercise?	☐ daily ☐ 1-3x/week ☐ 1x/week ☐ never Duration:

15. Are you a vegetarian: ☐ Yes ☐ No
16. Please check items excluded in your dietary intake: ☐ Fish ☐ Poultry ☐ Eggs ☐ Soy
17. Do you have any food allergies or intolerances? ☐ Yes ☐ No - Explain:
18. Food Dislikes:
19. Favorite Foods:
20. How many meals do you eat per day? ☐ 1 ☐ 1-3 ☐ 3+
21. Do you drink soda (diet or Regular) or sugar-containing beverages: How many daily:

****Please provide copies of your recent laboratory values prior to your appointment. CMP/BMP, Lipid panel, HgA1C and Glucose if available.**