

# Nutritional Health History

Whom may we thank for the referral \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

Reason for consultation and/or goals: \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? When? \_\_\_\_\_

Drink alcohol? \_\_\_\_\_ How much? When? \_\_\_\_\_

Do you drink caffeine every morning? \_\_\_\_\_

Do you have food allergies, restrictions, or sensitivities? Explain \_\_\_\_\_

Describe your daily energy levels: \_\_\_\_\_

Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while? Explain \_\_\_\_\_

Do you have Gastric reflux \_\_\_\_\_ gas \_\_\_\_\_ bloating or flatulence after meals? \_\_\_\_\_ Explain more: \_\_\_\_\_

How many bowel movements do you have a day? Explain \_\_\_\_\_

Rank your skin without lotion:  Very Dry  Dry  Normal  Oily  Combination

Do you crave any of the following?

Alcohol  Bread  Chocolate  Desserts

Fish  Fried Foods  Meat Fat  Milk Fat

Sugar  Other: \_\_\_\_\_

Do you take any nutritional supplements or vitamins? \_\_\_\_\_ If so, which ones? (Be specific. Attach sheets if necessary.)

Which prescription and over the counter medications to you take regularly? \_\_\_\_\_

Which oils do you use/consume?

Butter  Canola  Coconut Oil  Corn Oil  
 Crisco  Flaxseed Oil  Margarine  Mayonnaise  
 Olive Oil  Peanut Oil  Soybean Oil  Sun/Safflower  
 Vegetable Oil  Other: \_\_\_\_\_

**Please check any of the following that pertain to you (past or present – please mark present conditions with a P)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Acne                            | <input type="checkbox"/> Difficulty losing weight                      | <input type="checkbox"/> Kidney stones              |
| <input type="checkbox"/> Addiction (Alcohol, drugs)      | <input type="checkbox"/> Difficulty gaining weight                     | <input type="checkbox"/> Liver problems             |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Emotional problems (instability, sensitivity) | <input type="checkbox"/> Loose stools               |
| <input type="checkbox"/> Anorexia                        | <input type="checkbox"/> Emphysema                                     | <input type="checkbox"/> Memory loss or confusion   |
| <input type="checkbox"/> Anxiety or nervousness          | <input type="checkbox"/> Fainting                                      | <input type="checkbox"/> Nails, poor growth         |
| <input type="checkbox"/> Arthritis (Rheumatoid or Osteo) | <input type="checkbox"/> Gall bladder problems                         | <input type="checkbox"/> Panic attacks              |
| <input type="checkbox"/> Bladder infections (Cystitis)   | <input type="checkbox"/> Gout  | <input type="checkbox"/> Parasites                  |
| <input type="checkbox"/> Bloating, gas, or indigestion   | <input type="checkbox"/> Hair loss/Poor hair growth                    | <input type="checkbox"/> Pregnant or nursing mother |
| <input type="checkbox"/> Blood sugar problems            | <input type="checkbox"/> Headaches                                     | <input type="checkbox"/> Respiratory problems       |
| <input type="checkbox"/> Bronchitis                      | <input type="checkbox"/> Heart disease or problems                     | <input type="checkbox"/> Ringing in ears            |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Heartburn                                     | <input type="checkbox"/> Seizures                   |
| <input type="checkbox"/> Colds or Flu (frequent)         | <input type="checkbox"/> Hemorrhoids                                   | <input type="checkbox"/> Severe mood swings         |
| <input type="checkbox"/> Cold sores                      | <input type="checkbox"/> Herpes simplex or type II                     | <input type="checkbox"/> Skin conditions            |
| <input type="checkbox"/> Chronic fatigue                 | <input type="checkbox"/> High blood pressure                           | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Constipation                    | <input type="checkbox"/> High cholesterol                              | <input type="checkbox"/> Yeast infections           |
| <input type="checkbox"/> Dandruff                        | <input type="checkbox"/> Thyroid condition                             |   |
| <input type="checkbox"/> Depression                      | <input type="checkbox"/> Hot flashes                                   |   |

**Women: Please check all that pertain:**

- PMS
- Irregular periods
- Painful periods
- Loss of periods
- Birth control pills
- Menopause
- Painful intercourse
- Children
- Hysterectomy

**Men: Please check all that pertain**

- Frequent urination
- Difficulty urinating
- Difficulty with erection
- Loss of libido
- Prostate enlargement

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Explain briefly your weight loss history if it pertains to your current issues: \_\_\_\_\_

How is your dental health? \_\_\_\_\_

Have you ever had silver dental fillings? \_\_\_\_\_ How many? \_\_\_\_\_ Have they been removed? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ If so, what kind/How Often? \_\_\_\_\_

Please rate the following:

- |                        |                                    |                               |                               |                               |
|------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Daily energy level:    | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Energy after exercise: | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Daily stress level:    | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |

Do you have a support system of family and friends? \_\_\_\_\_

General enjoyment of life:  Excellent  Good  Fair  Poor

How many hours do you sleep/night? \_\_\_\_\_ How long does it take you to fall asleep? \_\_\_\_\_

Do you sleep throughout the night? If not, explain your pattern \_\_\_\_\_

Do you wake up feeling restored? \_\_\_\_\_

Please describe any other health concerns you think are important: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Jeanne Peters Notes on Physical Exam:**

Hair \_\_\_\_\_ Nails \_\_\_\_\_ Eyes/Lids \_\_\_\_\_

Skin condition \_\_\_\_\_ Tongue \_\_\_\_\_ Zinc Test \_\_\_\_\_

Other issues identified during Exam \_\_\_\_\_

**Meal Pattern:**

**Key Food/Nutrition Issues**

By signing below, you acknowledge that any dietary or supplemental suggestions made by Jeanne Peters RD are entirely nutritional in nature, and are not intended as the diagnosis, cure, or treatment for any disease or ailment. You also acknowledge that your physician is your primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that you make.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_