Monadnock
Nutrition Services

PERSONAL & MEDICAL HISTORY FORM

Name _____ Occupation_____

Have you ever been seen by a Dietitian/Nutritionist? ☐ Yes ☐ No If Yes: When? _____

List any nutrition goals you hope to achieve as a result of nutrition counseling:

_____

_____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Living with: ☐ Family ☐ Friends ☐ Alone

Number of Persons In Household _____ Number of children in Household_____

Past hospitalizations:_____

_____

Are you currently exercising? ☐ Yes ☐ No

Details: Type of exercise Minutes per day Days per week

_____

_____

Limitations on Activity: ☐ Yes ☐ No

Describe:_____

Highest Adult Weight & When: _____ Lowest Adult Weight & When: _____ Height: _____

Recent weight loss or gain? Explain: _____

Family Medical History: Check items that apply for your blood relatives, including children, brothers, sisters, parents, and grandparents.

☐ Alcohol/Substance Abuse
☐ Cancer
☐ Diabetes
☐ Depression
☐ Food sensitivity
☐ Stroke
☐ Heart disease
☐ High blood pressure
☐ Hyperlipidemia (high cholesterol)
☐ Liver Disease
☐ Smoking
☐ Thyroid dysfunction

Personal Medical History: Check problems you have or had that have been diagnosed by a physician or other health professional.

☐ Alcohol/Substance Abuse	☐ Heart problems	☐ Gallbladder disorder
☐ Cancer	☐ High blood pressure	☐ Anemia
☐ Diabetes	☐ High Cholesterol	☐ Gout
☐ Depression	☐ Sleep apnea	☐ Digestive Problems
☐ Food allergies	☐ Smoking	☐ Lactose intolerance
☐ Stroke	☐ Thyroid dysfunction	☐ Eating disorder
☐ Chewing difficulties	☐ Arthritis	☐ Liver disease

List any food allergies you have: _____

Smoking: ☐ Smoke cigarettes # cigarettes per day_____

☐ Smoke pipe/cigar

☐ Quit smoking in past year

☐ Nonsmoker

How many hours of sleep per night do you average per night?_____

Please rate your current stress level ☐ High ☐ Moderate ☐ Low ☐ None

Do you follow a special diet or eating style? ☐ Yes ☐ No

If yes, please describe: _____

Please list any strong overall food preferences:

_____

Females Only:

Age at time of first menses: _____

Date of your last menstrual period: _____

Number of days between periods: _____

Number of days period lasts: _____

Are you taking birth control pills? _____