Learn Feel Choose Nutrition
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Health History Form

Name:____ Date: _____________

Address:____

Home phone:________________ Work phone: ______________ Cell phone: ______________

E-mail address:__________________________ Gender: Female____Male____ Age: _____

Date of Birth: _________ Place of Birth: _____________ Occupation: ____________________

Health Insurance Company: ____________ Marital Status: _________Number of Children:_________

Height:____ Weight:_____Highest weight ever: ____Year ____ Lowest weight as an adult: ____Year _____

Where and when have you lived or traveled outside the U.S. and Canada? _____________________
____

Are you currently receiving health care? Y N

If yes, where and from whom: ____

____

If no, when and where did you last receive medical or health care?_____________________

____

What was the reason? ____
Date of most recent blood/lab work (ex. cholesterol, blood sugar, etc.)?____________________
Have you had a Vitamin D blood test done recently? If so, what is your level: _______________

What are your current health goals: ____

____

What concerns would you like to address? **How long have you had these conditions?**

1) ___________________________ ___________________________

2) ___________________________ ___________________________

3) ___________________________ ___________________________

In order to change these conditions, are you willing to make dietary and lifestyle modifications? Y N

Please list any other major health concerns past or present: ________________________

____

What hospitalizations or surgeries have you had?
__________________ Year: _______ __________________ Year: _______

***Medical (Men)* (please circle)**
Benign prostatic hyperplasia
Prostate cancer
Decreased sex drive
Infertility
Sexually transmitted disease
Other ______________________

***Medical (Women)* (please circle)**
Menstrual irregularities
Endometriosis
Infertility
Fibrocystic breasts
Fibroids/ovarian cysts
Polycystic ovarian syndrome
Premenstrual syndrome (PMS)
Peri/menopausal symptoms
Breast cancer
Pelvic inflammatory disease
Vaginal infections
Decreased sex drive
Sexually transmitted disease
Other _____________________
Date of last GYN exam _______
Mammogram ________
Abnormal PAP ________
Form of birth control ___________
# of children _________________
# of pregnancies _____________
C-section _________________
Age of first period _____________
Date - last menstrual cycle ______
Length of cycle __________ days
Interval of time between cycles _______days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) ________________
Surgical menopause
Menopause

Family History

Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart disease	High blood pressure	Kidney disease
Epilepsy	Arthritis	Glaucoma	Tuberculosis	Stroke
Anemia	Mental Illness	Asthma	Hayfever	Learning disabilities
Depression	Thyroid trouble	Gallstones	Food sensitivities	Migraines
Osteoporosis	Neurological problems	Infertility	Obesity	Skin problems

Other ____
What is your heritage? ____
Any other relevant family history? ____

Allergies

Are you hypersensitive or allergic to:
Any drugs:____
Any foods:____
Any environmental or chemical sensitivities: ____

Typical Food Intake

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To drink: ____

Eating Habits (please circle)
Skip meals - which ones ______________________________
How many meals do you eat daily: one, two, three
Graze (eat small frequent meals)
Generally eat on the run
Eat constantly whether hungry or not

Health Habits:
Tobacco: Cigarettes: #/day ____________ Cigars: #/day ______________
Alcohol: Wine: #glasses/d or wk _______ Liquor: #ounces/d or wk _______ Beer: #glasses/d or wk_______
Caffeine: Coffee: #6 oz cups/d __________ Tea: #6 oz cups/d ____________ Soda: #cans/d _______
Other sources _______________
Water: #glasses/d___________

When during the day is your energy the best? ___________________ worst? _______________________

Rate the level of stress that you are currently experiencing on a scale of 1-10 (1 being the lowest):__________

Identify the major causes of stress (ex. work, family, legal problems, etc.): ___________________________

Is your job associated with any potentially harmful chemicals (ex. pesticides, solvents, etc.)? _____________

Do you exercise regularly? Y N List the types of exercise you get in a typical week:

Type of Exercise ___________________ How often ______________ How long _____________
Type of Exercise ___________________ How often ______________ How long _____________
Type of Exercise ___________________ How often ______________ How long _____________

Current Medications and Nutritional Supplements

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping Pills	Y N
Antidepressants	Y N				

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking.

Name	**Dosage / Frequency**	**Duration**
______________________________	__________________________	_______________
______________________________	__________________________	_______________
______________________________	__________________________	_______________
______________________________	__________________________	_______________
______________________________	__________________________	_______________
______________________________	__________________________	_______________
______________________________	__________________________	_______________
______________________________	__________________________	_______________

Additional things you want to mention or discuss:

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