Dietitian Associates, Inc.

PATIENT HISTORY INFORMATION

Name _____ **Age**_____ **Female** □ **Male** □

Reason for Visit _____

_____

Past/Current Medical History: (please check □ all that apply)

Alcohol/Substance Abuse	□	Arthritis	□
Depression	□	Osteoporosis	□
Anemia	□	Gallbladder	□
Amenorrhea	□	GERD (Gastro Esophageal Reflux Disease)	□
Pre-Diabetes	□	Burping/Belching	□
Diabetes-Type 1	□	Nausea	□
Diabetes-Type 2	□	Vomiting	□
Gestational Diabetes	□	Gastroparesis	□
Hypoglycemia	□	Abdominal pain	□
Metabolic Syndrome	□	Abdominal Distension/Bloating	□
Hyperlipidemia	□	Colitis/Crohn's	□
High Blood Pressure	□	SIBO (small intestinal bacterial overgrowth)	□
High Cholesterol	□	Celiac Disease	□
High Triglycerides	□	Irritable Bowel Syndrome	□
Cardiovascular Disease	□	Diarrhea	□
Heart Attack	□	Constipation	□
Stroke	□	Gas/Flatulence	□
Sleep Apnea	□	Chewing/swallowing disorder	□
Do you use a C-pap? Yes □ No □		Underweight	□
Hypothyroidism	□	Eating Disorder	□
Hyperthyroidism	□	Overweight/Obesity	□
Thyroidectomy	□	Lap-Band Surgery	□
Cancer (type)_____		Gastric Sleeve Surgery	□
Food Allergy (list below)	□	Gastric Bypass Surgery	□
Food Sensitivities(list below)	□	Chronic Kidney Disease	□
Fibromyalgia	□	PCOS (Polycystic Ovary Syndrome)	□
Lupus	□	Asthma	□

Other Medical Issues:_____

Food allergy list: _____

Food Sensitivities list:_____

Dietitian Associates, Inc. 295 Germantown Bend Cove, Cordova, TN 38018; Phone: 901-759-9337 Fax: 901-759-7967

Name_____ **page 2**

Do you drink alcohol? **Yes** □ **No** □

If yes, number and type of drinks per week _____

Do you use tobacco? **Yes** □ **No** □

If yes, method: Cigarettes □ Cigar □ Snuff □ Chewing Tobacco □

How long have you used tobacco products? _____ Amount per day? _____

Have you quit using tobacco products? Yes □ No □ When did you quit? _____

Do you use recreational drugs? **Yes** □ **No** □

Please describe: _____

Current Medications:

Medication:	Purpose for Taking

Nutrition Supplements: (check all that you are taking)

Multivitamins □	Vitamin E □	Calcium □	St. John's Wort □
Vitamin D □	Vitamin B12 □	Iron □	Glucosamine □
Vitamin C □	Omega 3/fish oil □	Ginseng □	Ginkgo □

Other (please list) _____

_____

Lab Work:

Have you had lab work done in the past 6 months? **Yes** □ **No** □

If yes, please provide a copy or have your doctor's office fax a copy to 901-759-7967

Physical Activity:		
Type of exercise	**Length of Session**	**Times Per Week**

I certify that the above information is as accurate and as thorough as possible.
I understand that my dietitian uses the above noted information to aid in developing my nutrition recommendations.

Signature: _____ Date: _____