Vernon Nutrition Center - New Patient Form (Adult)

Patient Information

Name:_________________________ Age:_____ Date of Birth:________________
Address:_______________________
City: __________________________ State: __________ Zip Code:_____________
Home Phone #: (___)______________ Work Phone #: (___)_____________
E-mail address:____________________

Check One: Single ( ) Married ( ) Widowed ( ) Divorced ( )

Occupation:______________________ Employer:_______________________

In case of emergency, whom may we contact? ______________________________
Relationship_____________________ Phone #: (___)______________
Address: ________________________
City:______________ State:___________ Zip Code: ____________

How did you hear about our services: _______________________________________

Referring Physician
Name: _______________________________________
Medical Group: _______________________________
Address: _____________________________________
City: __________________ State: __________ Zip Code: ________________
Phone #: (___)____________________________

Primary Care Physician *(if different)*
Name: _______________________________________
Medical Group: _______________________________
Address: _____________________________________
City: __________________ State: __________ Zip Code: ________________
Phone #: (___)____________________________

Other Physician(s) *(if any)*
Name: _______________________________________
Medical Group: _______________________________
Address: _____________________________________
City: __________________ State: __________ Zip Code: ________________
Phone #: (___)____________________________

Name: _______________________________________
Medical Group: _______________________________
Address: _____________________________________
City: __________________ State: __________ Zip Code: ________________
Phone #: (___)____________________________

Copyright 2006. DietitianResource.com. All Rights Reserved.

Medical History Form

Please list any current or past medical conditions:

Medical Condition/ Problem	Date of Diagnosis

Please list current medications:

Medications Currently Taking	Reason for Medication	Dose	Times per day	Length of Time taken

Please list any medications that you are allergic to:

____

Please list any current vitamins, minerals, or herbal supplements you are taking:

Supplements Currently Taking	Reason for Supplement	Dose	Times per day	Length of Time taken

Copyright 2006. DietitianResource.com. All Rights Reserved.

Weight History

In the past 6 months have you gained or lost any weight? Yes ( ) No ( )
If yes, please explain: ___________________________________

What is your heaviest adult weight? __________ when? __________
What is your lowest adult weight? ___________ when? __________

Are you satisfied with your current weight? Yes ( ) No ( )
If no, what is your goal weight? ______________

Have you participated in any nutritional counseling programs in the past? Yes ( ) No ( )
If yes, please list: ____
____
____

Family History

Does your family have a history of: *(please check all that apply)*

Obesity ( ) Diabetes ( ) High Blood Pressure ( )
High Cholesterol/Triglycerides ( ) Heart Disease ( ) Cancer ( )
Other: _____________________

If checked yes to any above, please explain:
____
____

Nutrition Assessment

Do you have any food allergies? Yes ( ) No ( )
If yes, what foods:
____
____

Do you skip meals regularly? Yes ( ) No ( )
If yes, what meals?
____

Do you eat in relation to stress? Yes ( ) No ( )

Copyright 2006. DietitianResource.com. All Rights Reserved.

Do you have any food cravings? Yes ( ) No ( )
If yes, what foods?

____

Do you eat in the middle of the night? Yes ( ) No ( )

Have you ever binged or purged? Yes ( ) No ( )

Do you consume alcohol? Yes ( ) No ( )
If yes, how often and how much?

____

Do you currently smoke? Yes ( ) No ( )
If yes, how much?

____

If no, have you ever in the past? Yes ( ) No ( )

How many meals a week do you eat out at a restaurant or eat take-out?

____

Who is responsible for your food shopping and preparation?

____

Do you currently exercise? Yes ( ) No ( )
If yes, what type of exercise and how often?

____

If no, have you ever exercised in the past? Yes ( ) No ( )

Please check any of the following conditions that you currently experience:

Condition	**Yes**	**No**
Swallowing Problems		
Change in Taste		
Shortness of Breath		
Low Exercise Tolerance		
Irregular Heartbeat		
Heart Murmur		
Chest pains		
Poor appetite		
Heartburn/ Indigestion		

Condition	**Yes**	**No**
Nausea/ Vomiting		
Diarrhea		
Constipation		
Frequent urination		
Constant Thirst		
Snore		
Insomnia		
Daytime Sleepiness		
Fatigue		

Copyright 2006. DietitianResource.com. All Rights Reserved.

Food Recall

Please record a sample of what you eat on a typical day:

Breakfast ____________________
____
____
____

Snack ____________________
____

Lunch ____________________
____
____
____

Snack ____________________
____

Dinner ____________________
____
____
____

Snack ____________________
____

Copyright 2006. DietitianResource.com. All Rights Reserved.