

Nutrition & Health History Form

PERSONAL INFORMATION

DATE: _____

First Name: _____ Last Name: _____

Phone #: _____ E-mail: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Date of Birth (d/m/y): _____ Age: _____

Gender: Male Female Occupation: _____

Family Physician: _____ Phone#: _____

Referred By: _____

MEDICAL HISTORY

Are you currently taking any pills, drugs or medications? _____

Are you taking any vitamin / mineral / herbal supplements? _____

Are you allergic or sensitive to any foods? _____

Do you use any other health services? Yes No

If yes, what? _____

Please check all that apply:

Acid Reflux	Diabetes/High blood sugars	Irritable Bowel Syndrome
Anemia/Low iron	Hypoglycemia (low blood sugars)	Kidney Disease
Asthma	Eczema	Osteoporosis
Cancer	Diarrhea	Depression
Chronic Fatigue	High blood pressure	Heartburn
Constipation	High cholesterol	Headaches/migraine
Crohn's Disease	Thyroid Problems	Ulcers
Menopause	Eating Disorder	Celiac Disease

Other: _____

Previous surgeries (What type? When?): _____

Females Only:

Are you pregnant? Yes No If yes, how many months: _____

Are you breastfeeding? Yes No

DIET HISTORY

What is the reason for your visit? _____

Have you ever met with a Registered Dietitian or Nutritionist? Yes No

If yes, what was done at that time? _____

Have you ever followed a special diet? Yes No

If so, what type of diet and for how long? _____

Do you have any special dietary restrictions? (check all that apply):

- | | | |
|---|--|---|
| Vegetarian (ovo/lacto) <input type="checkbox"/> | Vegan <input type="checkbox"/> | Kosher / Halal <input type="checkbox"/> |
| Lactose intolerant <input type="checkbox"/> | Gluten free <input type="checkbox"/> | Other: _____ |
| Low salt/sodium <input type="checkbox"/> | Low cholesterol <input type="checkbox"/> | |

Who does the grocery shopping in your house? _____

Who does the cooking & food preparation in your house? _____

How much time do you have to devote to meal preparation and cooking? _____

How would you describe your cooking skill level on a scale of 1-5 (1=minimal skill, 5=superb skill):

How many times per week do you eat out? (restaurant, food court, cafeteria): _____

LIFESTYLE HABITS

Do you drink coffee? Yes No If yes, how many cups/day? _____

Do you drink tea? Yes No If yes, how many cups/day? _____

Do you drink pop? Yes No If yes, how many cups/day? _____

Do you drink water? Yes No If yes, how many cups/day? _____

Do you smoke? Yes No If yes, how much? _____

Do you consume alcohol? Yes No

Specify type of alcohol: _____ How often? _____

Do you exercise? Yes No If yes, how often? _____

How many hours of sleep do you normally get each night? _____