Name: ____________________________ Date:______________________

Age: ______ Insurance: _________________

Occupation: ________________________ Work hours: ________________

Diet History

Please list the diets you have tried, weight changes and time frames below:

Name of Diet	Start Date	Weight Lost	How long on Diet?	Weight Regained

Height _______________ Weight _______________

Has your weight changed in the past year? Yes No

If Yes: Gained_______lbs Lost__________lbs

What do you think is a realistic weight for you? _______Lbs

When did you last weigh that amount (realistic weight)? _________________________________

At what age do you feel weight became an issue for you? ________________________________

Do you feel that your eating habits are affected by stress and/or your emotions? Explain: ____________
____

Have you ever tried medication to lose weight? If Yes, what? ____________________________________
____

Have you tried any surgeries or procedures to lose weight? If yes, what? __________________________
____

Personal and Family Medical History

Please check the appropriate column if you or your immediate family (parents, sisters, brothers, or grandparents) have had any one of the following health problems:

	You	Family		You	Family
Diabetes			Orthopedic Problem		
High Blood Pressure			Arthritis		
Heart Attack			Gastrointestinal Problem		
High Cholesterol			Psychiatric Disorder		
Angina (chest pain)			Depression		
Asthma			Eating Disorder		
Cancer			Sleep Apnea		
Kidney Disease			Reflux		

Do you have any other medical issues we should know about?
____
____
____

Do you have any food allergies? ____

Do you have any food intolerances? ____

List your current medications:
____
____
____

Do you currently take any vitamins, minerals, dietary supplements or meal replacement products? Please list items and how often you take them:
____

Please list your daily meal regime:

Meal	Time	Place	Describe (what foods and how much)
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Other			

Who prepares meals in your home? ____

What other people live in your household? ____

Number of meals (per week) you eat away from home on weekdays?	Breakfast:	Lunch:	Dinner:
Number of meals (per week) you eat away from home on weekends?	Breakfast:	Lunch:	Dinner:

Do you drink alcohol? **Yes** **No** If Yes, how many drinks per week?_______________________

Do you skip meals? **Yes** **No** If Yes, which meals? ___________________________________

Reason for skipping? ____

List restaurants where you eat often: ____

____

____

____

Do you exercise? **Yes** **No** Days per week/duration: _______________________________

Type of exercise:____

Is there any reason you cannot or should not exercise? ____
____

Any other information you'd like the dietitian to know? ____
____
____
____

OFFICE USE ONLY:

BMI _______________

IBW _______________

FOOD GROUP	**AMOUNT**	**FOODS**
Dairy		
Grains		
Fruits		
Vegetables		
Protein/Meats		
Fats		
Beverages		
Snacks		

GOALS:

____
____
____
____
____
____
____