SHORE MEDICAL CENTER

Somers Point, NJ 08244

PATIENT ID/LABEL HERE:

OUTPATIENT NUTRITION: NUTRITION HISTORY

PATIENT PROFILE: *Patient to complete, comment as appropriate*

Name: _____ _____ **Male** _____ **Female**

Date of Birth: _____ **Age:** _____

Referring Physician: _____ **Primary Physician:** _____

Reason for appointment: _____

What do you hope to accomplish as a result of working with a dietitian?

_____

_____

What do you think will be your biggest challenge? _____

_____

How did you hear about our program? _____

MEDICAL HISTORY:

Medical History: Check if you have ever had/currently have one of the following conditions:

____ Allergies (food, drug, seasonal)	____ Diabetes – type I (insulin required)	____ Hyperlipidemia
____ Anorexia or Bulimia	____ Diabetes – type II (adult)	____ Iron Deficiency Anemia
____ Arthritis	____ Diabetes – gestational	____ Irritable Bowel Syndrome
____ Asthma	____ Diverticulosis	____ Kidney Disease
____ ADHD	____ Foot Problems	____ Knee Problems
____ Back Problems	____ Fibromyalgia	____ Lactating or Pregnant
____ Bowel Surgery	____ Heart condition (explain)	____ Osteoporosis
____ Cancer Type? _____	____ High Blood Pressure	____ Stroke
____ Celiac Disease	____ High Cholesterol	____ Thyroid Issues
____ Chronic Fatigue	____ High Triglycerides	____ Weight Loss Surgery

Other: _____

Family history of any medical conditions (if yes, please explain):_____

_____

_____

Dietitian's notes: _____

_____

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MEDICATIONS:

Please write all medications (including over the counter) here or provide a separate list.

Name	Dose	How Often?

VITAMINS/HERBAL SUPPLEMENTS:

Name	Dose	How Often?

Dietitian's notes: _____

_____

_____

OCCUPATION:

Do you work outside of the home? ____Yes ____No

What is your occupation? _____

What are your work hours? _____

Is your job: _____Active _____Inactive _____ N/A

ACTIVITY:

What type of exercise do you do? _____

How much? _____ avg # of minutes _____ days per week

Any challenges to physical activity? _____

Dietitian's notes: _____

_____

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GI SYMPTOMS:

Check if you have ever had/currently have one of the following conditions:

____ Abdominal discomfort	____ Dysphagia	____ Nausea
____ Constipation	____ Flatulence	____ Reflux
____ Diarrhea	____ Heartburn	____ Vomiting

EATING PATTERNS AND DIET HISTORY:

Allergies and Food Sensitivities: _____

_____

_____

Dietary Limitations (*dislikes, cultural/religious/ethnic preferences*): _____

_____

_____

Time/Prep Issues (explain):_____

_____

_____

Other (*Sleep patterns, stress/environmental issues*): _____

_____

_____

Are you following a particular diet? If yes, please specify: _____

Any previous diets? _____Yes _____No Type/Approx dates?

_____

_____

_____

Who is responsible for food shopping? _____

Who is responsible for cooking? _____

How often do you dine out? _____

Dietitian's notes: _____

_____

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Name: _____ **Date of Birth:** _____

Current Eating Pattern

Weekday	Weekend
B:	
Snack:	
L:	
Snack:	
D:	
Snack:	
Beverages/Fluids	
Est. Kcal (Dietitian to complete this section)	

Dietitian's notes: _____

_____

_____

***Date/Time Reviewed*:** _____