SHS Nutrition, LLC

Patient Medical History and Lifestyle Assessment

Name: _____ Date: _____

General

When was the date of your last blood test? _____.

Please either give us a copy of your results or have your physician send us a copy.

Please provide us the details of all medications, vitamins, remedies, herbal supplements, and similar that you are taking:

Name	Start date	Dosage	How Often	Reason for Taking

List any allergies and your reactions to any medications, foods, or other substances:

Are you lactose intolerant?

Are you on a fluid restricted diet?

Do you have difficulty chewing or swallowing foods?

Please tell us about any other dietary restrictions:

_____

Have you experienced any recent (please circle)? Abnormal weight gain Abnormal weight loss

Medical History

Do you have any of the medical conditions listed below? Please circle all that apply.

Heart disease	Heart attack	Heart bypass surgery	Angioplasty	High blood pressure
High cholesterol	Diabetes: type 1 or type 2	Stroke	Cancer	Depression/Anxiety
Anorexia	Bulemia	Hypothyroid	Hyperthyroid	Bariatric Surgery: Gastric Bypass/ LapBad/ Gastric Sleeve
Ulcer	GERD	Celiac Disease	IBS	Sleep Apnea
Renal Disease	Liver Disease	Gallstones	Kidney Stones	Anemia: Iron or B12
High Triglycerides	Pacemaker	Lung Disease	Multiple Sclerosis	Asthma
Arthritis	Osteoporosis	Fibromyalgia	PCOS	Gout

Has your father, brother, or son died before the age of 55 from heart related problems?

Yes No

Has your mother, sister, or daughter died before the age of 65 from heart related problems?

Yes No

Are any members of your immediate family overweight or obese? Yes No

Who (father, mother, brother, sister, child)? _____

Have you or any of your family members had bariatric surgery? Yes No

If yes, who and which surgery did they have?

_____

_____

In your mind do you feel that they were successful? Yes No

If no, why?

_____

_____

Are you considering bariatric surgery? Yes No

If you have diabetes, how do you control it (please circle all that apply)?

Use diet Use insulin injections Use oral medications Don't control it.

What is your fasting glucose level? _____ or don't know

What is your Hba1c level?_____ or don't know

Substance Abuse

How much do you smoke?

Cigarettes: _____ packs per day for ____ years

Other (please list): _____ ____ times per week

How long ago did you quit? _____ months and _____ years

On average, how much do you drink (provide the number of drinks per week)?

Beer: _____ Wine: _____ Liquor: _____

How often do you take recreational drugs or prescription drugs at a frequency greater than that recommended by your physician?

Mental Health

Which are significant sources of stress in your life (circle all that apply)?

Family relationships Housing Legal problems Money problems

Health problems Work problems Other [describe: _____]

What do you do to relieve stress? _____

How often would you characterize your stress level as being high (please circle)?

Never Rarely Sometimes Often Usually Always

Do you ever do the following?	Yes	No
I turn to food when I am stressed or upset		
I think about food a lot		
I feel out of control with my eating		
I binge eat		
I eat when I am not physically hungry		
Food helps me deal with my feelings		
I feel in control when I restrict my eating		
Feel depressed		
Feel anxious		

Do you currently see a therapist? If yes, please provide name and contact information.

_____

Do you have any other medical conditions that you would like to tell us about?

_____

_____

_____

Describe your present weight :

_____

How satisfied are you with the way you look at this weight?

_____

How much do you / did you weigh:

Now: _____ 3 months ago: _____ 6 months ago: _____ 1 year ago: _____

What is your lowest adult body weight:_____

How old were you? _____

What is your highest adult body weight:_____

How old were you?_____

What do you think are some of the factors that contribute to your weight?

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At what weight have you felt your best or do you think you would feel your best?

_____

How much weight would you like to (check) □ Lose or □ Gain? _____

Do you feel your weight affects your daily activities ? Yes No

If yes, how so ?

_____

_____

_____

_____

What weight loss/fitness/lifestyle programs have you tried in the past?

_____

_____

_____

_____

What usually goes wrong with your weight-loss/lifestyle change programs?

_____

_____

_____

_____

From 1-10, How committed are you to making change? _____

What are some potential obstacles that my get in the way of your success?_____

_____

_____

_____

In the last month, how many times did you exercise:_____

Do you currently belong to a gym (circle): Yes No

If yes, what is the name and city it is located in: _____

Women's Health

Are you pregnant? Yes No

Are you perimenopausal or menopausal? Yes No