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HEALTH HISTORY

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home#: _____ Cell#: _____ Work#: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

Email: _____

Who referred you to our office? _____

Are you on Facebook, Instagram, or Twitter? _____

Please provide usernames:

_____

_____

_____

3 DAY DIET RECALL

Record everything that you eat and drink. Please be as specific as possible as to size/amount of portion. Indicate how hungry you were and what you were doing while eating. (i.e. Watching TV, driving, standing, talking, etc.)

This must be filled out prior to first appointment.

DAY 1

BREAKFAST

_____
_____
_____
_____

MID-MORNING SNACK

_____
_____
_____

LUNCH

_____
_____
_____
_____

AFTERNOON SNACK

_____
_____

DAY 2

BREAKFAST

_____
_____
_____
_____

MID-MORNING SNACK

_____
_____ _
_____ _

LUNCH

_____
_____
_____
_____

AFTERNOON SNACK

_____
_____

DAY 3

BREAKFAST

_____
_____
_____
_____

MID-MORNING SNACK

_____
_____
_____

LUNCH

_____
_____
_____
_____

AFTERNOON SNACK

_____
_____

DINNER

_____

_____

_____

_____

AFTER DINNER SNACK

_____

_____

_____

DINNER

_____

_____

_____

_____

AFTER DINNER SNACK

_____

_____ _

_____ _

DINNER

_____

_____

_____

_____

AFTER DINNER SNACK

_____

_____

_____

Do you smoke?

☐ Yes

☐ No

How much_____ How long _____

If you quit, when did you quit? _____

Do you drink alcohol? _____

How much/how often? _____

Do you use recreational drugs? _____ Which ones? _____

How much/how often? _____

Do you have food allergies, restrictions, or sensitivities?

_____

_____

Describe your daily energy levels:

_____

Do you get noticeable irritable, light-headed, or weak if you haven't eaten for a while?

_____

Do you crave any of the following?

☐ Sugar ☐ Meat ☐ Fat ☐ Chocolate ☐ Fish ☐ Alcohol

☐ Desserts ☐ Milk ☐ Bread ☐ Fried Foods ☐ Other, please list below

_____

Do you take any nutritional supplements or vitamins? _____ If so, which ones? Be specific.

_____

_____

_____

_____

_____

Which prescription and over the counter medications do you take regularly? Please include present and past chemotherapeutic agents and/or immunotherapy and if you have undergone any fertility treatment and dates.

_____
_____
_____
_____
_____
_____

Which oils do you use/consume?

- ☐ Butter
- ☐ Peanut Oil
- ☐ Canola
- ☐ Margarine
- ☐ Corn Oil
- ☐ Sun/Safflower
- ☐ Olive Oil
- ☐ Crisco
- ☐ Mayonnaise
- ☐ Coconut Oil
- ☐ Vegetable Oil
- ☐ Flaxseed Oil
- ☐ Soybean Oil
- ☐ Other _____

How is your dental health?

_____

Have you ever had a filling removed or replaced?

- ☐ Yes (date) _____
- ☐ No

If yes, how many? _____ When? _____

How many bowel movements do you have a day? _____

Do you have any abnormal bowel movements such as loose stool, diarrhea, blood in your stool or impacted feces? _____

Gastroenterologist _____

Colonoscopy:

- [ ] Yes (date) _____
- [ ] No

Endoscopy:

- [ ] Yes (date) _____
- [ ] No

Rank your skin condition without lotion:

- [ ] Very Dry
- [ ] Dry
- [ ] Normal
- [ ] Oily
- [ ] Combination

Please check off any of the following that pertain to you now or in the past.

(Please mark PRESENT conditions with a P next to it):

- [ ] Acne
- [ ] Addiction (alcohol, drugs)
- [ ] Anemia
- [ ] Anorexia/Bulimia (circle one)
- [ ] Anxiety or nervousness
- [ ] Arthritis (Rheumatoid or Osteo)
- [ ] Asthma
- [ ] Attention/Focus Disorder
- [ ] Autoimmune Disease _____
- [ ] Bladder infections (Cystitis)
- [ ] Bloating, gas, or indigestion
- [ ] Blood Disorder _____
- [ ] Blood Sugar problems
- [ ] Bronchitis
- [ ] Cancer _____
- [ ] Colds or flu (frequent)
- [ ] Cold Sores
- [ ] Chronic Fatigue
- [ ] Chronic Pain
- [ ] Constipation
- [ ] Dandruff
- [ ] Depression
- [ ] Diabetes I (insulin dependent)

- [ ] Diabetes II (adult onset)
- [ ] Difficulty losing weight
- [ ] Difficulty gaining weight
- [ ] Emotional problems (instability or sensitivity)
- [ ] Emphysema
- [ ] Epstein Barr Virus (EBV)
- [ ] Fainting
- [ ] Gall Bladder Problems
- [ ] Gout
- [ ] Hair loss or poor hair growth
- [ ] Headaches
- [ ] Heart disease or problems
- [ ] Hemorrhoids
- [ ] Herpes simplex or type II
- [ ] Hiatal Hernia
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] HIV
- [ ] Hot flashes
- [ ] Hypoglycemia
- [ ] Infections _____
- [ ] Infertility _____
- [ ] Insomnia
- [ ] Intestinal problems
- [ ] Kidney stones
- [ ] Learning Disabilities
- [ ] Liver problems
- [ ] Lyme's Disease
- [ ] Memory loss or confusion
- [ ] Nails, poor growth
- [ ] Panic attacks
- [ ] Parasites
- [ ] PCOS
- [ ] Pregnant or nursing
- [ ] Reflux/Heart burn
- [ ] Respiratory problems
- [ ] Ringing in ears
- [ ] Seizures (current or past)
- [ ] Severe mood swings
- [ ] Skin conditions
- [ ] Stroke
- [ ] Suicidal Tendencies
- [ ] Thyroid conditions
- [ ] Ulcer
- [ ] Yeast Infections

Primary Care Physician: _____

Oncologist (if applicable): _____

Surgeon (if applicable): _____

Please list any hospitalizations with dates and events:

_____
_____
_____
_____

Women: Please check all that pertain:

- ☐ Last menstrual period _____
- ☐ PMS
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Painful periods
- ☐ Loss of periods
- ☐ Hormone Replacement Therapy
- ☐ Birth control pills
- ☐ Menopause: _____
- ☐ Painful intercourse
- ☐ Number of pregnancies: _____
- ☐ Children (give ages and sex) _____
- ☐ Vaginal or c-section delivery _____
- ☐ Hysterectomy
- ☐ Miscarriages
- ☐ Are you currently trying to become pregnant? _____
- ☐ How long have you been trying to become pregnant? _____
- ☐ Ob/Gyn _____ Fertility Specialist _____

Men: Please check all that pertain:

- ☐ Frequent urination
- ☐ Difficulty urinating
- ☐ Difficulty with erection
- ☐ Loss of libido
- ☐ Prostate enlargement

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

_____
_____
_____
_____
_____
_____

Please rate the following:

Daily energy level: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Energy level after exercise: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Daily stress level: ☐ Very High ☐ High ☐ Moderate ☐ Low

Do you have a good support system of family and friends? _____

General enjoyment of life: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How many hours do you sleep? _____ Do you sleep throughout the night? _____ Do you wake up without an alarm? _____ Do you wake up feeling rested? _____ Do you fall asleep within 15 minutes? _____

How many nights a week do you sleep through the night? _____

Do you have any concerns with your weight? _____

Please check one: underweight ☐ overweight ☐

How many diets have you been on in order to lose weight? _____

Which ones? _____

What were your results? _____

What are your challenges when trying to lose weight? _____

_____

Have you ever taken weight loss supplements or "diet pills"? _____

If so, which ones? _____

When did you take weight loss supplements or medication? _____

How many diets have you been on in order to gain weight? _____

What are your challenges when trying to gain weight? _____

_____

Have you ever taken supplements or medication to gain weight? _____

If so, which ones? _____

When did you take supplements or medication to gain weight? _____

What do you feel triggered your initial weight gain? (Check One)

☐ HEREDITAY ☐ EATING HABITS ☐ STRESS ☐ HORMONES

☐ BOREDOM ☐ SMOKING CESSATION ☐ OTHER _____

Was your weight gain: (Check One)

☐ SUDDEN ☐ GRADUAL ☐ PROBLEM SINCE CHILDHOOD

Exercise:

Do you exercise? If so, what kind? _____

How often/since when? _____

_____

Please describe any health concerns you think are important:

_____

_____

_____

_____

_____

What are your nutritional goals?

_____
_____
_____
_____
_____

By signing below, I acknowledge that any dietary or supplemental suggestions made by this office are entirely nutritional in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. I also acknowledge that my physician is my primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that I make. I understand that insurance is not accepted for this service, there are no diagnostic codes or forms available for this procedure, and no insurance claim forms will be filled out for this service. I further understand that there are no refunds for this service.

Date: _____

Name: _____

Signature: _____