Date:

HEALTH AND NUTRITION HISTORY

Please complete this form and bring to your appointment. If a question does not apply, please leave it blank. This information will help your dietitian better understand your needs.

Please note: *We request payment at time of service for co-pays and self-pay patients. South Denver Cardiology Associates will bill your insurance for nutrition services, however not all insurance companies cover nutrition counseling. Please check with your insurance before your appointment to verify coverage. We are happy to provide a superbill or encounter form for you to submit to your insurance company.*

Nutrition Services Self Pay: $150 for 45-60 min initial session $75 for 30 min follow-up session

Name_____ Date of Birth _____

Address_____

City _____ Zip Code _____

Phone _____ Referring Physician _____

Email_____

Sex ❑ female ❑ male Occupation _____

Reason for nutrition consult _____

MEDICAL HISTORY:

Please check if you have or have had any of the following condition(s):

❑ high blood pressure	❑ high cholesterol	❑ heart disease
❑ type 2 diabetes*	❑ pre-diabetes	❑ sleep apnea
❑ arthritis	❑ depression	❑ thyroid condition
❑ gastrointestinal disorder	❑ gall bladder disease	❑ kidney disease
❑ liver disease	❑ pacemaker	❑ cancer
❑ eating disorder	❑ chronic constipation	❑ migraines
❑ irritable bowel syndrome	❑ other _____	

**If you have diabetes*:

How long have you had diabetes? _____

Have you had diabetes education in the past? ❑ no ❑ yes (where) _____

Do you check your blood sugars? ❑ no ❑ yes (how often) _____)

Height: _____ Weight: _____ Typical Blood Pressure _____

LABS (date _____**)**

Total cholesterol _____ LDL Cholesterol _____ HDL Cholesterol _____ Triglycerides _____

Glucose _____ C-reactive protein _____ Hemoglobin A1c _____

FAMILY HISTORY

❑ high blood pressure ❑ heart disease ❑ diabetes ❑ stroke
❑ alcoholism ❑ osteoporosis ❑ cancer (type): _____
❑ thyroid disorder ❑ other _____

Food allergies/sensitivities_____

Current medications_____

_____

Dietary supplements _____

_____

Do you <u>frequently</u> experience any of the following?

❑ diarrhea ❑ constipation ❑ bloating/gas
❑ dry skin ❑ heartburn or reflux ❑ light-headed or dizzy
❑ colds or flu ❑ water retention ❑ sinus problems
❑ headaches ❑ allergies ❑ mood swings
❑ muscle twitches ❑ PMS ❑ bleeding gums
❑ easy bruising ❑ canker sores ❑ tingling in fingers/toes
❑ brittle nails

ACTIVITY

Do you consider yourself ❑ very active ❑ somewhat active ❑ sedentary ❑ very sedentary

List any exercise or physical activities you participate in on a regular basis (types, amounts):

List any limitations for physical activity _____

Using the following scales, please answer the following questions by placing an X on the line below:

1. How would you rate your knowledge regarding general nutrition?

……..

0	5	10
I don't know anything	I know the basics	I am an expert

2. How do you apply your nutrition knowledge to your everyday lifestyle?

……..

0	5	10
I never eat healthy	I eat healthy three times per week	I eat healthy daily

3. How important is making lifestyle changes, such as adjusting your diet or increasing your activity?

……..

0	5	10
Not very important	Somewhat important	Very important

4. How ready you are right now to make lifestyle changes?

……..

0	5	10
Not very ready	Somewhat ready	Very ready

5. How confident are you are that you can make lifestyle changes?

……..

0	5	10
Not very confident	Somewhat confident	Very confident

6. How are your current stress levels?

……..

1	3	5
Very relaxed	Managing ok	Very stressed

7. What lifestyle change(s) are you considering? _____

8. How much time are you willing to spend each week on making lifestyle changes? (for example, increasing activity, planning meals, journaling food) _____

9. What barriers or obstacles challenge you in reaching your goal?

- ❑ lack of nutrition knowledge
- ❑ lack of time/hectic schedule
- ❑ lack of organization
- ❑ don't like to cook
- ❑ don't know how to cook
- ❑ emotional eating (overeating or not eating enough due to stress, boredom, anxiety, loneliness, feeling scared, sad, relaxed, happy)
- ❑ other: _____

10. Do you have a good support system to help you accomplish your goals?

11. Check all that apply:

- ❑ My family eats most meals together.
- ❑ I eat most of my meals alone.
- ❑ Family meals are served at regular times on most days.
- ❑ Another member of my family is on a special diet or is trying to lose weight.

12. How many times in a typical week do you and your family eat the following:

- ❑ Heat and serve meals _____
- ❑ Home-cooked meals _____
- ❑ Fast foods _____
- ❑ Restaurant meals _____
- ❑ Take out (grocery or restaurant) _____

13. What is the most important goal you want nutrition counseling to help you reach?

Weight History: *If weight loss is not a goal, please skip this box.*

1. What would weighing less do for you? _____
2. What is your goal weight? _____lbs. How long ago were you at this weight? _____
3. At what weight would you consider the following:
   _____ ideal weight _____ disappointed weight
   _____ happy weight _____ acceptable weight
4. Have you tried to lose weight in the past?

   If no, you have finished the questionnaire.

   If yes, how? Please check all that apply:

   - ❑ Diet(s): describe_____
   - ❑ Medication(s): list_____
   - ❑ Other methods: describe_____

   If you have lost weight in the past:

   How much weight did you lose? _____ lbs. over _____ (time)

   How much of this weight, if any, did you gain back? _____lbs.

   What plan worked best for you and why? _____
5. In the past year, have you tried to manage your weight with vomiting, diet pills, laxatives or not eating?
   ❑ no ❑ yes
6. Do you frequently eat when bored, lonely or stressed, or feel out of control when you eat? ❑ No ❑ Yes