Date:

HEALTH AND NUTRITION HISTORY

Please complete this form and bring it 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 the 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: $99 for 45-60 min initial session $50 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
❑ type 2 diabetes*
❑ arthritis
❑ gastrointestinal disorder
❑ liver disease
❑ eating disorder
❑ irritable bowel syndrome
❑ high cholesterol
❑ pre-diabetes
❑ depression
❑ gall bladder disease
❑ pacemaker
❑ chronic constipation
❑ other ___________________________________
❑ heart disease
❑ sleep apnea
❑ thyroid condition
❑ kidney disease
❑ cancer
❑ migraines

**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 frequently 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 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