

NUTRITION MEDICAL HISTORY

Name: Date of Birth:

Sex: **M F** Phone #: Dept:

Home Address:

G #: Occupation:

If referred to our services, please state by whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I’m seeking this service for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: Phone #:

Address:

Emergency Contact: Relation:

Phone #1: Phone #2:

1. Have you ever been diagnosed or treated for any of the following heart-related problems?

NO YES WHEN

High blood pressure   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Angina (chest pain)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart murmur   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Valvular heart disease   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Myocardial infarction (heart attack)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart disease or problems   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

2. Have you ever experienced any of the following signs and / or symptoms?

NO YES WHEN

Severe shortness of breath or rapid

heart rate with mild or normal activity

Ankle swelling/edema   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Severe dizziness or fainting   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claudication or severe muscle cramps   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(especially in legs)

Low blood sugar   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Long term fatigue without being sick   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

1. Do you have asthma or any other pulmonary problems?  NO  YES

Comments:

4. Have you had any surgery as a result of an injury?  NO  YES

Body region and when: Rehabilitation:  NO  YES

Comments:

5. Do you have a neuromuscular disorder, rheumatoid disorder or muscular problem that

is worsened by physical activity?  NO  YES

If so, explain the problem, **body region affected** and **when** the pain occurs?

6. Have any one of your **parents and/or siblings** been diagnosed with any of the following?

NO YES Relative Age of Onset

Heart attack/heart problems

High blood pressure

Diabetes I or II

Comments:

6. List any medications you are currently taking:

Medication Prescribed For Taken Since

1.

2.

3.

4.

Comments:

7. Do you have any medical, physical or emotional conditions which would require a modified exercise program? Explain:

8. Smoking status:  Never Smoked  Used to Smoke  Currently Smoke\*

\*Packs per day (amount): \*Number of years smoked:

If you quit smoking, what year did you quit?

Do you currently use cigars, pipes or smokeless tobacco products (i.e., chew, snuff)?  NOYES

Have you ever been diagnosed with chronic bronchitis or emphysema:  NOYES

If yes, explain:

9. How many days per week do you currently exercise:  6-7  3-5  2-1  NONE

How long do you typically exercise:  30+ min  20-29 min  10-19 min  < 10 min

At what level or intensity do you typically exercise:  vigorous  moderate  low

10. What is the date of your last physical? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The above stated information is true and accurate to the best of your knowledge.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Reviewed By: Date:

*Office Use Only*

Client was referred to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_