2841 DeBarr Rd. Suite 43
Anchorage, AK 99508
Phone 907-274-7847
Fax 907-274-7845

Nutrition History

Date: _____

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Marital Status: □ Single □Married □Divorced □Widowed □Separated

Home phone: _____Work Phone: _____

E Mail: _____

Source of referral: □Self referred □ Physician/Provider □Other

Referring/Primary Care Provider and telephone number:

_____

Name Telephone

Family Heritage (Check all that apply):

□ White □ American Indian/Alaska Native □ Black/African American

□ Asian □ Native Hawaiian/Pacific Islander □ Spanish/Latino/Hispanic

Occupation: _____ Hours worked per week: _____

□ **Please describe your reason(s) for Meeting with the Dietitian today:**

_____

_____

Do you have any of the following nutrition related concerns?

□ Unanticipated weight loss
□ Unanticipated weight gain
□ Undesired weight gain
□ Kidney disease
□ Lactose (milk) problems
□ Food Intolerances
□ Desire for Weight Loss Surgery
□ Desire for Weight Loss
□GI or Colon concerns
□ Difficulty with portion management
□ Difficulty chewing/swallowing
□ Diagnosed Food Allergies

Please list food intolerances or food allergies:

_____

Have you previously attempted any diets to assist with the following problems?

□blood pressure □cholesterol levels

□blood glucose management (diabetes, prediabetes)

□ weight loss *(please continue to next page)*

If yes, please describe: _____

Diet for other reason not previously mentioned: _____

Have you at any time in the past met with another registered dietitian, or licensed nutritionist? □ Yes (when?) _____ □ No

Whose nutritional guidance do you value now, or have you valued in the past?

_____

Do you follow any particular eating regimen/nutrition plan currently (please name or describe):

What are your goals with this plan? _____

Have you attempted any of the following diets for weight loss?:

(please mark all that apply and briefly describe)

	When & How Long?	Total Weight Loss Achieved	Pounds Regained
□ Dietitian			
□Physician Supervised			
□Weight Watchers			
□Jenny Craig			
□Overeaters Anonymous			
□NutriSystem			
□Optifast			
□Slim Fast			
□Eating Disorder / Disordered Eating Pattern			
□Self-initiated or fad diets			
□Alli			
□Phen-Fen			
□Redux			
□Meridia			
□Amphetamines			
□Xenical			
□Ephedra			
□Herbal Life/Metabolife			
□Hydroxycut			
□Behavioral Therapy			
□Psychotherapy			
□Exercise Program			

Medical and Health Care Treatments for Weight Loss

□ (Previous) Weight Loss Surgery			
□Jaw Wiring			
□Other Surgery			
□Acupuncture			
□Hypnosis			
□Other			

Do you exercise? If yes, what type? _____

How many times a week do you exercise? _____

How many minutes per exercise session? _____

Have you ever been advised by a doctor to limit your exercise in any way?

_____

Has your weight changed in the past year? □ Yes □No How much? _____

Do you use alcohol? □ No □ Yes

How much and how often? _____

Do you use or have you used tobacco products? □ No □ Yes

When did you quit? _____

What hobbies bring enjoyment to your life?

_____

_____

_____

How do you handle stress?

_____

_____

_____

Describe your overall health

_____

_____

_____

Medications

Please list all of your medications, *prescription and OTC*

Name Dose Frequency Doctor

Do you have any drug allergies or intolerances? What type of reactions did you experience?

What are your health care goals and how can we facilitate those goals?

Patient signature: _____ Date: _____

Reviewed by: _____ Date: _____

Diabetes Education

Have you previously had any diabetes education?
□Yes (when where?) _____ □No
If yes, did you find this helpful? □Yes □No

Do you current check your own blood sugars with a home glucose meter?
?Yes ?No
If yes: Do you know the name of your meter? _____
How old is the meter you current use? _____
Do you like your current meter? ?Yes ?No
How often do you current check your blood sugars? _____
Do you keep a record of your blood sugars? ?Yes ?No
Did you bring you glucose meter with you today? ?Yes ?No
Do you know your blood sugar number goals? ?Yes ?No
Fasting goals: _____ 2 hours after meal goals:_____

Are there any topics below you would like to discuss specifically today?
Please mark all that apply

□Nutritional Guidelines
□Medicines (by mouth, or via injection)
□Blood Sugar Monitoring Goals
□A1c test
□Cholesterol test goals
□Exercise Guidelines
□Foot Care
□Complications associated with Diabetes
□Other Concerns regarding diabetes
□Stress management
□ Other _____