



**PERSONAL HEALTH INFORMATION continue:**

Immunity

- \_\_\_\_\_ Cancer (solid tumor or blood related) Type: \_\_\_\_\_  
\_\_\_\_\_ Family history of Cancer: Type: \_\_\_\_\_  
\_\_\_\_\_ Chronic Fatigue  
\_\_\_\_\_ Upper Respiratory Allergies  
\_\_\_\_\_ Recurring ear infections  
\_\_\_\_\_ Recurring sinus infections  
\_\_\_\_\_ Auto-immune: Type \_\_\_\_\_

Endocrinology

- \_\_\_\_\_ Diabetes mellitus (IDDM or NIDDM)  
\_\_\_\_\_ Thyroid Disease  
\_\_\_\_\_ Graves  
\_\_\_\_\_ Hypothyroidism  
\_\_\_\_\_ Acute Thyroiditis Remission date: \_\_\_\_\_

Dermatology

- \_\_\_\_\_ Varicose Veins  
\_\_\_\_\_ Spider Veins  
\_\_\_\_\_ Thinning Hair  
\_\_\_\_\_ Thinning Skin  
\_\_\_\_\_ Acne  
\_\_\_\_\_ Psoriasis

Women's Health Issues

- \_\_\_\_\_ PMS  
\_\_\_\_\_ Ammenorhea menstration stopped)  
\_\_\_\_\_ Dysmenorhea (painful menstration)  
\_\_\_\_\_ Peri-menopause  
\_\_\_\_\_ Menopause  
\_\_\_\_\_ Neurological Disorder Type: \_\_\_\_\_  
\_\_\_\_\_ Recurring Vaginal yeast infections  
\_\_\_\_\_ Recurring Urinary Tract Infections

Men's Health Issues

- \_\_\_\_\_ Benign prostatic hyperplasia  
\_\_\_\_\_ Bacterial prostatitis

Bone and Joint

- \_\_\_\_\_ Arthritis  
\_\_\_\_\_ Rheumatoid  
\_\_\_\_\_ Osteoarthritis  
\_\_\_\_\_ Orthopedic Problem Type: \_\_\_\_\_

Central Nervous System

- \_\_\_\_\_ Chronic Depression  
\_\_\_\_\_ Mild to moderate anxiety  
\_\_\_\_\_ Insomnia  
\_\_\_\_\_ Headaches:  
\_\_\_\_\_ Cluster  
\_\_\_\_\_ Miagraines  
\_\_\_\_\_ Sinus  
\_\_\_\_\_ Tinnitus (ringing in the ears)  
\_\_\_\_\_ Memory loss associated with aging

Vision and Sight

- \_\_\_\_\_ Macular degeneration  
\_\_\_\_\_ Night vision  
\_\_\_\_\_ Dry eyes  
\_\_\_\_\_ Cataracts

Other

- \_\_\_\_\_ Cigarette smoking  
\_\_\_\_\_ Alcohol consumptio: Drinks per week \_\_\_\_\_  
\_\_\_\_\_ Obesity (30% or more overweight)(if yes, please answer weight management Information below)  
\_\_\_\_\_ Overweight (if yes, please answer weight management Information below)

**Please fill out this page only if weight loss is a goal**



1. What's the greatest accomplishment you've ever made?

\_\_\_\_\_

2. What's the biggest change you've ever made?

\_\_\_\_\_

3. What is the one talent you have that you are most proud of?

\_\_\_\_\_

\_\_\_\_\_

**ACTIVITY AND EXERCISE HISTORY**

Please check the answer which most closely describes your normal daily activity level. (This activity does not include exercise.)

- Mostly sedentary
- Mildly active-some walking and moving about
- Very active-little sitting, a lot of movement
- Heavy physical activity, lifting and moving heavy objects

Please indicate the type of exercise you do (if any), duration, frequency and perceived exertion (i.e., 1=light, 3=moderate, light sweat, 6=somewhat hard, 10=very hard)

ACTIVITY	DURATION minutes	FREQUENCY per week	INTENSITY perceived exertion
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How consistent have you been with the above exercise(s)?

\_\_\_\_\_ months  
\_\_\_\_\_ years

If you have never exercised before, check the reasons for not starting a program of physical fitness?

- Felt uncoordinated     Embarrassed about physical size
  - Felt uncomfortable     Embarrassed about wearing gym clothes
  - Never liked it     Didn't know how to get started
- Other \_\_\_\_\_

If at some time you had an exercise routine established, why did you stop?

\_\_\_\_\_

**LIFESTYLE HISTORY INFORMATION:**

FOOD ALLERGIES OR INTOLERANCES ? \_\_\_\_\_ IF SO WHAT FOODS ? \_\_\_\_\_

DO YOU SMOKE CIGARETTES? \_\_\_\_\_

HOW MANY MEALS DO YOU EAT A DAY ? \_\_\_\_\_

SKIP-----> BREAKFAST, LUNCH AND/OR DINNER

HOW MANY SNACKS DO YOU EAT A DAY ? \_\_\_\_\_

WHO PREPARES THE MEALS ? \_\_\_\_\_

% OF MEALS EATEN AT HOME \_\_\_\_\_

% OF MEALS EATEN OUT PER WEEK \_\_\_\_\_

TYPES OF RESTAURANTS FREQUENTED \_\_\_\_\_

ARE YOU IN A DIETARY RUT? \_\_\_\_\_ WHERE DO YOU SHOP FOR GROCERIES? \_\_\_\_\_

HOW MUCH PURE WATER DO YOU DRINK PER DAY? \_\_\_\_\_

HOW MUCH COFFEE DO YOU DRINK PER DAY? \_\_\_\_\_ ounces

LOWEST WEIGHT \_\_\_\_\_ - DATE \_\_\_\_\_ HIGHEST WEIGHT \_\_\_\_\_ - DATE \_\_\_\_\_

PRESENT WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_ DESIRABLE WEIGHT OR CLOTHING SIZE \_\_\_\_\_

**To be filled out by Nutritionist upon body composition testing:**

Impedance _____	Date _____	Lean Muscle mass _____	Body fat _____	Ratio _____ :
Impedance _____	Date _____	Lean Muscle mass _____	Body fat _____	Ratio _____ :
Impedance _____	Date _____	Lean Muscle mass _____	Body fat _____	Ratio _____ :
Impedance _____	Date _____	Lean Muscle mass _____	Body fat _____	Ratio _____ :

**PLEASE LIST ALL PRESCRIBED MEDICATIONS AND THE APPROXIMATE DURATION OF TIME TAKING THESE MEDS:**

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**OVER-COUNTER MEDICATIONS:**

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**VITAMIN/MINERAL OR OTHER NUTRITIONAL SUPPLEMENTS: (please specify doses) or if you are coming into my office, you can bring them for our consult**

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*Dear Client,*

*Thank you for completing the questionnaire. **Please keep a VERY DETAILED WRITTEN RECORD of everything you eat for the next three days.** If you have recent labs, please send me a copy via email or have your physician fax them to (541) 923-2082. All of the information will be invaluable to me in educating you to achieve your health goals.*

*Diana Davis, M.Ed., LDN, RD*