**Health History Questionnaire**

*The following information is confidential and will not be revealed to anyone outside Nutrition and Wellness Solutions, LLC without your written consent.*

**DATE COMPLETED:**

**PERSONAL INFORMATION**

Last Name:       First Name:       Middle Initial:

Date of Birth:       Gender:

Height:       Weight:

Home Address:

City:       State:       Zip Code:

Home Phone:       Work Phone:

Cell Phone:       Email Address:

**MEDICAL HISTORY:**

*Indicate if you have or have ever had any of the following conditions:*

|  |  |  |  |
| --- | --- | --- | --- |
| *Condition* | *Presence* | *Age of Onset* | *Explanation* |
| Heart disease | Yes  No |  |  |
| High blood pressure | Yes  No |  |  |
| High cholesterol | Yes  No |  |  |
| Heart attack/surgery | Yes  No |  |  |
| Stroke | Yes  No |  |  |
| Skipped/rapid heart beats | Yes  No |  |  |
| Shortness of breath | Yes  No |  |  |
| Reflux or heartburn | Yes  No |  |  |
| Diabetes | Yes  No |  |  |
| Cancer | Yes  No |  |  |
| Thyroid disease | Yes  No |  |  |
| Kidney disease | Yes  No |  |  |
| Liver disease | Yes  No |  |  |
| Asthma | Yes  No |  |  |
| Osteoporosis | Yes  No |  |  |
| Irritable bowel syndrome | Yes  No |  |  |
| Depression/anxiety | Yes  No |  |  |
| Dizzy spells | Yes  No |  |  |
| Unusual fatigue | Yes  No |  |  |
| Other: | Yes  No |  |  |

**FAMILY HISTORY**

*Please describe your family history of any of the following conditions, if applicable.*

|  |  |  |
| --- | --- | --- |
| *Condition* | *Family Member* | *Age of Onset* |
| Heart disease |  |  |
| High blood pressure |  |  |
| High cholesterol |  |  |
| Heart attack/surgery |  |  |
| Stroke |  |  |
| Skipped/rapid heart beats |  |  |
| Shortness of breath |  |  |
| Reflux or heartburn |  |  |
| Diabetes |  |  |
| Cancer |  |  |
| Thyroid disease |  |  |
| Kidney disease |  |  |
| Liver disease |  |  |
| Asthma |  |  |
| Osteoporosis |  |  |
| Irritable bowel syndrome |  |  |
| Depression/anxiety |  |  |
| Dizzy spells |  |  |
| Unusual fatigue |  |  |
| Other: |  |  |

**MEDICATIONS**

*Please list medications you are currently taking and the reason for taking them.*

|  |  |
| --- | --- |
| *Medication* | *Reason for Taking* |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**VITAMINS, MINERALS, SUPPLEMENTS**

*Please list any supplements you are currently taking, the dosage per day, and the reason for taking them.*

|  |  |  |
| --- | --- | --- |
| *Supplement* | *Dosage per Day* | *Reason for Taking* |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**TOBACCO AND ALCOHOL USAGE**

Do you currently smoke or use tobacco products? Yes  No

Have you ever smoked or used tobacco products? Yes  No

If so, how much per day?

Quit date, if applicable:

Do you consume alcohol? Yes  No

If so, how many drinks (per day or per week)?

**EXERCISE AND PHYSICAL ACTIVITY**

*Over the past 6-12 months, please describe your typical exercise routine.*

|  |  |  |  |
| --- | --- | --- | --- |
| *Type of Exercise* | *Frequency (days/week)* | *Duration (hours/day)* | *Intensity*  *(easy, moderate, hard)* |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**WEIGHT HISTORY AND EATING PATTERNS**

Are you satisfied with your current weight? Yes  No

Have you attempted to change your weight in the past? Yes  No

If yes, please explain (i.e., did you follow a specific diet, join a weight loss program, how much weight did you lose or gain?).

Have you ever purposely restricted your food intake and obtained what you or others felt was an extremely low or unhealthy weight? Yes  No

If yes, please explain:

Have you ever thrown up, used laxatives, or exercised for extremely long periods of time to try to control your weight? Yes  No

If yes, please explain:

**WEIGHT HISTORY AND EATING PATTERNS (continued)**

Have you ever felt unable to stop eating when you wanted to? Yes  No

If yes, please explain:

Have you ever consumed food or drink during the course of your normal sleep hours?

Yes  No

If yes, please explain:

Do you generally feel hungry before meals and snacks? Yes  No

How many meals do you eat each day?

How many snacks do you eat each day?

Do you consume caffeinated beverages? Yes  No

If yes, please describe the amount and frequency of beverages consumed.

Do you frequently experience diarrhea, constipation or intestinal bloating? Yes  No

How many times a week do you dine out?

*To the best of my knowledge, the information I have provided is accurate. I will agree to inform Heather Fink, MS, RD, CSSD of any changes in my health status.*

Signature of Client:       Date:

Signature of Parent of Legal Guardian:       Date:

**CANCELLATION POLICY**

*I understand that I must give 24 hours minimum advanced notice for any cancellations or rescheduling of appointments. If I do not do so, I agree to pay in full for the time I reserved.*

Signature of Client:       Date: