VIRGINIA HOSPITAL CENTER

Adult History Form
Medical Nutrition Therapy

Name:	**Date of Birth:** **Age:**
Address: _____ _____	**Home phone:** **Cell phone:** **Work phone:** **Email:** **Best way to contact you: [ ]Home [ ]Cell [ ]Work [ ] Email**

Referring Physician:	
Reason for today's visit:	
Height: _____ Current Weight:_____ Goal Weight: _____	
Has your weight changed in the past year? **[ ]** No **[ ]** Yes How much? _____ **[ ]** Gain **[ ]** Loss	
Marital Status: [ ] Single **[ ]** Married **[ ]** Divorced **[ ]** Widowed **[ ]** Separated	
How many people live in your household other than yourself? _____ **Relationship to you?**	
Race/Ethnicity (check all that apply) **[ ]** White **[ ]** Native American **[ ]** Black or African American **[ ]** Multi-race **[ ]** Asian **[ ]** Hispanic/Latino **[ ]** Native Hawaiian or other Pacific Islander	
What level of schooling have you completed? **[ ]** Elementary **[ ]** High School Diploma **[ ]** Some College **[ ]** College/University Degree **[ ]** Technical **[ ]** Military Training **[ ]** Graduate School **[ ]** Other:	
Do you use computers: [ ] to email **[ ]** to look for health and other information	
Occupation:	
Do you have specific educational needs? [ ] No **[ ]** Yes ***** What kind?	
How do you learn best: [ ] Listening **[ ]** Reading **[ ]** Observing **[ ]** Doing	
Do you have a history of the following (check all that apply) ?	

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[ ] Abnormal lipids [ ] Heart Disease [ ] Arthritis [ ] Cancer Type: [ ] High blood pressure [ ] Circulation problems [ ] Liver Disease	[ ] Dental or mouth problems [ ] Numbness/Pain (hands/feet) [ ] Depression [ ] Diabetes Pre-diabetes Type 1 Type 2 [ ] Kidney disease	[ ] Skin [ ] Eye or vision problems [ ] Stomach or bowel problems [ ] Sexual Problems [ ] Foot problems [ ] Thyroid disease [ ] Other:

If female:

Are you pregnant? [ ] No [ ] Yes

Are you considering pregnancy? [ ] No [ ] Yes

Nutrition and Lifestyle

What food planning methods have you followed in the past? (Check all that apply)

[ ] No method [ ] Food pyramid/Healthy choices [ ] Calorie Counting

[ ] Carbohydrate Counting [ ] Low Carbohydrate [ ] Weight Watchers

[ ] Other:

Have you been instructed by your physician to follow specific diet guidelines? (i.e., Gluten Free, Low Potassium, High/low fiber, etc.)

[ ] No

[ ] Yes Please specify: _____

Typical Day Schedule: Please fill in the times of your meals and snacks, provide us with the type and amount of food you eat, this will help develop your meal plan.

	Time	Typical Meals (Best example please)
I wake up at		
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Evening meal		
Bedtime snack		
I go to bed at		

Who mostly does the grocery shopping?

Who mostly does the cooking?

Do you have any food allergies? If yes, please list:

Do you have Lactose Intolerance? [ ] No [ ] Yes

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Do you drink alcohol? **[ ]** No **[ ]** Yes Amount and times per week:

Do you use tobacco?
[ ]No **[ ]** Yes **[ ]** Quit

If yes, would you like information about smoking cessation? **[ ]** No **[ ]** Yes

How many times per week do you exercise?
[ ] 0 **[ ]** 1-2 **[ ]** 3-4 **[ ]** 5-6 **[ ]** more than 6

What type of exercise?

For how many minutes do you exercise?
[ ] 1-10 **[ ]** 11-15 **[ ]** 16-30 **[ ]** More than 30

How often do you eat outside of your home (please check appropriate boxes):

	Never	**Sometimes**	**Frequently**
Breakfast			
Lunch			
Dinner			
Snacks			

What are some of the meals/restaurants you frequent?

List medications, including over-the-counter medications and vitamins:

Do you have medication allergies? **[ ]** No **[ ]** Yes ***What Kind?**

Concerns

Please state whether you agree, are neutral or disagree with the following statements:

I feel good about my general health: **[ ]** agree **[ ]** neutral **[ ]** disagree
My level of stress is high: **[ ]** agree **[ ]** neutral **[ ]** disagree
I have been sleeping well: **[ ]** agree **[ ]** neutral **[ ]** disagree

How do you handle stress:

What do you feel are your most important concerns in regards to your health?

What would you like to learn from this program?

Patient Signature: _____Date: _____

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****Please do not write below this line****

Clinician Assessment Summary

Date: _____ Clinician Signature: _____