SMART WEIGHT LOSS

CREATING HEALTHIER LIVES

New Patient Booklet

The health information you provide in this Starter Booklet will never be disclosed to outside parties, nor will it be used for marketing purposes. It will be used to assist your Dietitian with your Dietary Treatment Program. The contact information you provide will help your Dietitian to contact you to schedule your Dietary Consultations.

How Did You Hear About Us? ____

Patient First Name: ___________________ Last Name:______________________________

Street Address: ________________________________City: ________________ State: ____

Zip: _________ Email Address: ____

Preferred Contact Phone: (_____)________________ Best Hours To Call: ___________

What is the purpose of your visit:____

____

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Dietetics, Nutrition &Fitness Specialist
Serving: Dade, Broward,
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Mon-Fri 10am-7pm
954-274-5811
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Date:___________________________

Health History Questionnaire

The Health History Questionnaire section supplements information obtained in your Symptom Survey with past medical problems and treatments. This information is vital for the Dietitian in identifying dietary considerations apart from your food sensitivity test results. Please answer all questions completely and accurately.

Name:	Date of Birth: Sex:[ ] Male [ ] Female

Total Cholesterol____________ HDL________ LDL_________ Triglycerides________________ Additional labs:	Ht._________Wt.______ What is your usual wt.?________________ Any Wt. changes? Yes_____ No________ If Yes, how much?____	BMI___________ Underweight (<18) Normal (<24.9) Overweight (25-29.9) Obese (30-39.9) Morbid Obesity (>40)	Blood Pressure: /

Marital Status:	Occupation:

List Your Main Health Complaints (In order of importance)	Duration of Problem
1.	
2.	
3.	
4.	

Surgical History (Please list all surgeries)

1.	2.	3.

Circle (Or Write In) All Medical Conditions You Have Been Previously Diagnosed With			
Arthritis, Rheumatoid	Crohn's Disease	Hypoglycemia	Fructose Intolerance
Arthritis, Osteo	Depression	Interstitial Cystitis	Other:
Asthma	Diabetes	Irritable Bowel Syndrome	Other:
Attention Deficit Disorder	Eczema	Lactose Intolerance	Other:
Celiac Disease	Gastroesophageal Reflux	Migraine	Other:
Chronic Fatigue Syndrome	Hives	Rhinitis	Other:
Colitis	Hypertension	Ulcerative Colitis	Other:

List All Medications You Currently Take Regularly OR As Needed (Prescription & OTC)

Drug	Dosage	# Times Per Day	Start Date

Allergy History

Does Anyone In Your Family Have Allergies? [ ] Yes [ ] No

If Yes: [ ] Parent [ ] Sibling [ ] Other Blood Relative:

If Yes, What Are They Allergic To? [ ] Food [ ] Medication [ ] Pollen [ ] Dust [ ] Other:

Do you Have Any Known Allergies? [ ] Yes [ ] No

List All Foods, Additives, and Medications That You <u>KNOW OR SUSPECT</u> You Are Allergic To:

Do you drink alcohol?   Yes   No If yes, how many alcoholic drinks per week? _________ Did you smoke? Yes No If yes, how long? ___________

List All Vitamins & Herbs Taken On A Regular Basis

Diet History

# of times you typically skip Breakfast each week:	How many snacks do you typically eat per day?					
# of times you typically skip Lunch each week:	***Bold below all snacks you typically eat***					
# of times you typically skip Dinner each week:	Chips	Cookies	Candy	Fruit	Veggies	Other

Place a letter next to each beverage indicating how often you consume it using the following scale:
D = Daily, W = Weekly, M = Monthly 0 = Never or almost never.

____Water ____Coffee ____Tea ____Soda ____Milk ____Juice ____Wine ____Beer ____Other:

How many times do you typically eat out each week?

How many times per week do you eat at a "Fast Food" restaurant?

Please provide a list of the food you normally consume in 1day:

Where did you eat:	**Time & Meal**	**Food**	**Portion**
Sample:Home/work/out	12pm: lunch	Chicken salad	1cup

Program Goals	
The positive benefits experienced by changing your diet and lifestyle can be tremendous. What Health Goals do you want to accomplish? Whether your aim is to decrease the frequency or severity of specific symptoms, or to increase energy and general wellness, your Dietitian will work with you to design a plan that will help you achieve those goals. The first step is to write down your goals and then discuss them with your Dietitian to develop your personalized plan.	
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Any Additional information that you think will benefit your dietary consultation:____
____
____
____
____
____
____
____