# Patient Intake Form (Past Medical History)

Name_____ Date_____

**BACKGROUND QUESTIONS**

What prompted you to seek dietitian services at this time?

_____

What are your personal goals we can help you achieve?

_____

How ready are you to make lifestyle changes? (choose #) _____ (Not ready 1 2 3 4 5 Very ready)

**OVERALL HEALTH QUESTIONS**

Date of your last physical exam: _____ Date of last blood testing: _____

How do you rate your health? (check one) ☐ excellent ☐ good ☐ fair ☐ poor

Height: _____ Current Weight: _____

What was your lowest body weight as an adult? _____ Highest? _____

**<u>REVIEW OF SYSTEMS</u> (check all that apply):**

**Respiratory**

☐ Asthma

☐ Emphysema

☐ Snoring

☐ Sleep apnea

☐ History of pneumonia

☐ Chronic bronchitis

☐ Other:

_____

**Cardiovascular**

☐ High blood pressure

☐ Heart disease/heart attack

**CARDIOVASCULAR CONTINUED (check all that apply):**

☐ Congestive heart failure

☐ Ankle or feet swelling

☐ Blood clot

☐ Other: _____

**Gastrointestinal**

☐ Nausea/vomiting

☐ Abdominal pain

☐ Heartburn/GERD

☐ Belching

**GASTROINTESTINAL CONTINUED (check all that apply):**

☐ Ulcer disease

☐ Colitis

☐ Constipation

☐ Crohn's

☐ Diarrhea

☐ Gallbladder disease/stones

☐ Celiac disease

☐ IBS

☐ Other: _____

**Genitourinary**

☐ Difficulty urinating

☐ Urinary incontinence

☐ Recurrent urinary infections

☐ Infertility

☐ Sexual problems

☐ Abnormal menstrual period

☐ Kidney stones

☐ Enlarged prostate

☐ Other: _____

**Musculoskeletal**

☐ Aching muscles/joints

☐ Arthritis

☐ Low back pain

☐ Vertebral disc problem

☐ Torn ligaments/muscle soreness

**MUSCULOSKELETAL CONTINUED (check all that apply):**

☐ Osteoporosis/Osteopenia

☐ Other: _____

**Endocrine**

☐ Diabetes Mellitus

☐ Thyroid disease

☐ Elevated cholesterol

☐ Elevated triglycerides

☐ Gout

☐ Other: _____

**Skin**

☐ Infection (boils, ulcers, etc.)

☐ Chronic rashes

☐ Bruises easily

☐ Excessive hair growth (females)

☐ Other: _____

**Other**

☐ Low energy level

☐ Depression, Bipolar, ADD

☐ Anxiety disorder, OCD,

☐ Panic attacks

☐ Psychological/Psychiatric care

☐ History of cancer,
Type:_____

☐ Anemia

☐ Headache

☐ Other: _____

**Do you have family history of the following? (check all)**

☐ High Blood Pressure ☐ High Blood Cholesterol

☐ Diabetes ☐ Thyroid Disease ☐ Obesity ☐ Heart Disease

☐ Cancer ☐ Other_____

**List history of surgeries:**

_____

**Preventative care screenings and diagnostic tests you have had (check all that apply):**

☐ Sigmoidoscopy/Colonoscopy

☐ Cardiac Stress Test

☐ Bone Density

☐ Mammogram

☐ Prostate/Testicular Exam

List current medications and dosages:

_____

_____

List current vitamins/supplements:

_____

Do you have any allergies or intolerances to medications or foods?

_____

How often do you use tobacco? _____

How often do you drink alcohol? _____

Average hours of sleep each night: _____ Is your sleep restful? ☐ Yes or ☐ No

How would you rate your stress level? (choose #) _____ (Low 1 2 3 4 5 High)

How do you cope with daily stressors?

_____

Anything else you would like me to know?

_____

_____

_____