

Medical - Nutrition Assessment.		Patient form.	Today's Date
This assessment will provide information to help create a food plan to meet your nutritional needs. Please complete the entire form. This is a confidential part of your medical record and it will be kept in this office.			
Introduction and Anthropometric			
Patient Name		Patient #.	
Address:			Zip Code
City	State		Phone Number
Birth date.	Occupation.		Previous Occupations.
Date of last physical exam.		Date of last dental exam.	
Current Marriage Status. Married Single Divorced Widowed		Highest Level of Education Completed. None High School Some College Bachelors Masters Doctorate Certification	
List all medicines you are currently taking (include nonprescription drugs):			
Chief Concerns about your weight. List in order of importance: health concerns, symptoms, or problems you are experiencing.			
Height:		Current Weight	Usual Weight
Desired Weight.		For Office Use. Estimated Calorie Needs.	BMI.
List Food Allergies			
List Other Allergies (drugs or environmental).			

Medical - Nutritional Assessment			
Lifestyle. Answer the following questions			
How often do you like to shop for groceries?	Often	Sometimes	Not Much
How often do you like to cook?	Often	Sometimes	Not Much
How often do you eat out?	Often	Sometimes	Not Much
How quickly would you like to lose weight?	Gradual	Moderate	Rapid

Habits. Answer the following questions.			
Do you drink alcohol more than 4 times per week?	No	Yes	If yes, how much do you drink per week?
Do you drink caffeinated beverages (Coffee, cola) more than 2 times per day?	No	Yes	If yes, what do you drink and how much do you drink per day and how often ? 3 cup of coffee per day.
Do you smoke cigarettes more than 4 times per week?	No	Yes	If yes, how much do you smoke per day?

