

NUTRITION HEALTH ASSESSMENT

NAME (First, Last, Middle)

ADDRESS (Street, City, State, Zip code)

TELEPHONE

____(____)____-_____

SEX

M_____ F_____ Height_____ Weight_____

AGE _____ Date of Birth _____

ETHNIC BACKGROUND

1. ____ White, not of Hispanic background
2. ____ Black, not of Hispanic Background
3. ____ Hispanic
4. ____ American Indian/Alaskan native
5. ____ Asian
6. ____ Pacific Islander

MARITAL STATUS

1. ____ Single
2. ____ Married
3. ____ Widowed
4. ____ Divorced/Separated

MEDICAL HISTORY

Have you ever been told by a doctor that you had any of the following conditions?

	NO	YES	DON'T KNOW
1. Diabetes (Type I or II)	_____	_____	_____
2. Kidney Disease	_____	_____	_____
3. Heart disease or angina	_____	_____	_____
4. High blood pressure	_____	_____	_____
5. Stroke	_____	_____	_____
6. Overweight/obesity	_____	_____	_____
7. Diverticulosis	_____	_____	_____
8. Cancer	_____	_____	_____
If yes, what kind?			
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9. Chronic constipation	_____	_____	_____
10. High cholesterol	_____	_____	_____
11. Other serious illnesses	_____	_____	_____
If yes, explain.			

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the diseases listed above? YES ____ NO ____

If yes, explain.

GENERAL INFORMATION

Do you take vitamins/minerals or herbal supplements? YES ____ NO ____ If yes, list.

Here is a list of activities that people may do in their free time. How frequently do you do any of these things?

	Once a week	A few times a month	A few times a year
1. Walking more then 20 minutes at a time.	_____	_____	_____
2. Active sports	_____	_____	_____
3. Jogging or running	_____	_____	_____
4. Swimming	_____	_____	_____
5. Gardening, fishing, hunting	_____	_____	_____

Are you currently on a special diet? YES ____ NO ____

If yes, explain.

How many times a week do you eat out? _____

Have you lost or gained any weight recently? YES ____ NO ____

If yes, explain.

List any medications you are currently taking.

Please list any concerns or information you would like to discuss that have not been addressed above.
