DEBRA DIET WORKS

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Nutrition/Medical History Record

NAME: _____
Last First Middle Initial
STREET: _____ CITY: _____
STATE: _____ ZIP CODE: _____
HOME PHONE: _____ CELL _____WORK: _____
EMAIL: _____ OCCUPATION:_____
LIST FAMILY MEMBERS: _____
MARITAL STATUS: MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____
BIRTH DATE: _____/ _____ / _____ AGE: _____ HEIGHT (non shoes): _____ SEX: M _____ F _____

WEIGHT HISTORY: YOUR MAXIMUM WEIGHT (non pregnant):_____ WEIGHT AT AGE 20:_____
WEIGHT 1 YEAR AGO: _____ PRESENT WEIGHT: _____ DESIRED WEIGHT: _____
ATHLETIC ACTIVITIES/EXERCISE: _____

MEDICAL HISTORY: HISTORY OF MENTAL ILLNESS and/or PSYCHOLOGICAL COUNSELING:
_____
IMMEDIATE FAMILY HISTORY:
DIABETES: ____ GOUT: ____ HEART TROUBLE: ____ HIGH B.P. ____ STROKE ____ OTHER _____
DESCRIPTION OF ANY MEDICAL PROBLEMS: _____

DAILY MEDICATIONS:

NAME	AMOUNT	REASON	DURATION

NUTRITIONAL HISTORY - SUPPLEMENTS: (including vitamins, minerals, herbs, fiber supplements, etc.)

NAME	AMOUNT	REASON	DURATION

PREVIOUS DIETS YOU HAVE FAILED:

TYPE	DATES/LENGTH OF TIME STAYED ON	RESULTS

HAVE YOU HAD SURGERY FOR OBESITY IN THE PAST (give date): _____
ARE YOU CONSIDERING IT NOW: _____
FOOD ALLERGIES/INTOLERANCES: _____
REASON FOR VISIT TODAY (goals): _____
_____
HOW OFTEN DO YOU EAT OUT PER WEEK (include take-out meals): LUNCH: _____ DINNER: _____
BREAKFAST: _____ FAST DOOD MEALS PER WEEK: _____
DO YOU DRINK ALCOHOL: _____ WHAT: _____ HOW MUCH: _____ (circle) PER WEEK or DAY
CHECK YOUR USUAL ENERGY LEVEL AT EACH TIME:
A.M.: GOOD: __ FAIR__ POOR __ MID DAY: GOOD: __ FAIR __ POOR __ P.M. GOOD:__ FAIR __POOR __
FOODS YOU CRAVE/WHAT TIME: _____