

NUTRITION MEDICAL HISTORY

Name: Date of Birth:

Sex: **M F** Phone #: Dept:

Home Address:

G #: Occupation:

If referred to our services, please state by whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I’m seeking this service for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: Phone #:

Address:

Emergency Contact: Relation:

Phone #1: Phone #2:

1. Have you ever been diagnosed or treated for any of the following heart-related problems?

 NO YES WHEN

High blood pressure [ ]  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Angina (chest pain) [ ]  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart murmur [ ]  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Valvular heart disease [ ]  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Myocardial infarction (heart attack) [ ]  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart disease or problems [ ]  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

2. Have you ever experienced any of the following signs and / or symptoms?

 NO YES WHEN

Severe shortness of breath or rapid [ ]  [ ]

heart rate with mild or normal activity

Ankle swelling/edema [ ]  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Severe dizziness or fainting [ ]  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claudication or severe muscle cramps [ ]  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(especially in legs)

Low blood sugar [ ]  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Long term fatigue without being sick [ ]  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

1. Do you have asthma or any other pulmonary problems? [ ]  NO [ ]  YES

Comments:

4. Have you had any surgery as a result of an injury? [ ]  NO [ ]  YES

Body region and when: Rehabilitation: [ ]  NO [ ]  YES

Comments:

5. Do you have a neuromuscular disorder, rheumatoid disorder or muscular problem that

is worsened by physical activity? [ ]  NO [ ]  YES

If so, explain the problem, **body region affected** and **when** the pain occurs?

6. Have any one of your **parents and/or siblings** been diagnosed with any of the following?

 NO YES Relative Age of Onset

Heart attack/heart problems [ ]  [ ]

High blood pressure [ ]  [ ]

Diabetes I or II [ ]  [ ]

Comments:

6. List any medications you are currently taking:

 Medication Prescribed For Taken Since

1.

2.

3.

4.

Comments:

7. Do you have any medical, physical or emotional conditions which would require a modified exercise program? Explain:

8. Smoking status: [ ]  Never Smoked [ ]  Used to Smoke [ ]  Currently Smoke\*

\*Packs per day (amount): \*Number of years smoked:

If you quit smoking, what year did you quit?

Do you currently use cigars, pipes or smokeless tobacco products (i.e., chew, snuff)? [ ]  NO**[ ]** YES

Have you ever been diagnosed with chronic bronchitis or emphysema: [ ]  NO**[ ]** YES

If yes, explain:

9. How many days per week do you currently exercise: [ ]  6-7 [ ]  3-5 [ ]  2-1 [ ]  NONE

How long do you typically exercise: [ ]  30+ min [ ]  20-29 min [ ]  10-19 min [ ]  < 10 min

At what level or intensity do you typically exercise: [ ]  vigorous [ ]  moderate [ ]  low

10. What is the date of your last physical? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The above stated information is true and accurate to the best of your knowledge.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Reviewed By: Date:

*Office Use Only*

Client was referred to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_