Lenox Hill Outpatient Nutrition
178 E. 85th St. 2nd Floor
New York, NY 10028

Nutrition Health History Form

Last Name: _____ First Name: _____Date of Visit: ____/____/_____

Date of Birth (MM/DD/YEAR): ____/____/_____ Age:_____ Sex:_____ Primary Phone:(_____)_____

Referred By (required):_____ Referring Provider Phone Number: (_____)_____

Patient Email:_____ Date of last blood work (MM/YEAR): _____

Height:_____ Estimated Current Weight:_____

1. What problems/issues bring you here today?

_____

_____

_____

2. PAST MEDICAL HISTORY (*Please check-off all that applies to you):* __NO PAST MEDICAL HISTORY

Cardiovascular
__Heart Attack/Angina
__High Blood Pressure
__Arrhythmia/Palpitation
__Heart Failure/CHF
__Heart Surgery
__Stents/Angioplasty
__Peripheral Vascular Disease

Hematologic
__Anemia
__Blood Clots
__Sickle Cell Disease
__Lyme Disease
__MRSA
__HIV/AIDS
__Hepatitis: A B C

GI
__Ulcer/Gastritis
__Acid Reflux/GERD
__Inflammatory Bowel Disease (Colitis/Crohn's)
__Celiac Disease
__Diarrhea
__Constipation
__Nausea/Vomiting
__Irritable Bowel Syndrome
__Diverticular Disease

Neurological
__Stroke/TIA
__Seizures
__Neuropathy
__Concussion

Musculoskeletal
__Lupus/SLE
__Fibromyalgia
__Arthritis
__Osteoporosis

Endocrine
__Diabetes
__Thyroid disorder
__Menstrual Disorder
__Hypoglycemia (low blood sugar)

Oncology
__Cancer
Type: _____
Treatment:
_____

Respiratory
__Asthma
__COPD
__Obstructive Sleep Apnea
__Smoker: Y N Former
Packs Per Day:____
For how many years?:_____

Mental Health
__Anxiety
__Depression
__Bipolar
__Schizophrenia
__Dementia
__ADD/ADHD
__Eating Disorder

Other Medical or Surgical History: _____

_____

3. Allergies:

Please indicate any food and/or drug allergies:

_____

_____

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DOB:_____/_____/_____	

4. **Medications and vitamin/mineral supplements** (CURRENT) with doses: Please list ALL medications, including over the counter, herbs, and vitamin supplements

Medication/ Supplement	Dosage Amount	Frequency	Last Dose: Date and Time

5. Weight History:

Do you weigh yourself? Yes ☐ No ☐ If so, how often? _____

Has your weight changed in the past 3-6 months?: ☐ Yes ☐ No If so, please specify:_____

Usual Body Weight (lbs) :_____ Highest Weight: _____ Desired Weight: _____

6. Exercise

How many days per week do you exercise?: _____ *For how many minutes?:*_____

Please describe the type of activity (e.g., walking, jogging, biking, etc.):

_____

7. Nutrition History

Have you seen a Dietitian/Nutritionist before? YES ☐ NO ☐

Has your doctor recommended that you follow a specific eating plan? YES ☐ NO ☐

If so, please specify:_____ Do you currently follow this eating plan? YES ☐ NO ☐

Who does most of the food shopping and preparation?:_____

How many days during the week do you eat out?: _____

Please specify where you eat out:_____

Please circle all the types of beverages you may drink over the course of a week:

Juice/ Fruit Drinks Regular Soda Diet Drinks Milk Coffee Tea Water

Alcohol intake: _____ drinks per week/ month

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How many meals do you eat per day?: _____ How many snacks per day?: _____

Each day, how many servings of the following do you have:

Water: _____cups/day Dairy:_____ Fruit:_____ Vegetables:_____

Please rate your level of stress from 0 to 10: _____ Hours of sleep per night: _____

What do you consider to be the biggest issue/challenge with your diet (e.g., limited access to healthy food, busy lifestyle, stress, significant cravings for sweets, etc.)?_____

Have you ever been concerned about being able to afford meals for you and your family? ☐ YES ☐ NO

Are you currently on any government subsidized nutrition assistance programs (SNAP)? ☐ YES ☐ NO

TYPICAL FOOD INTAKE: Please write down everything you ate and drank over the past 24 hours if you did not complete the requested food journal.

Breakfast: Time: _____	
Snack: Time: _____	
Lunch: Time: _____	
Snack: Time: _____	
Dinner: Time: _____	
Snack: Time: _____	

8. **Other nutrition concerns:** *Please indicate any specific nutrition goals or concerns you would like to discuss at today's visit:*

_____

_____

PATIENT USE ONLY: I certify that the above information is correct to the best of my knowledge. I will not hold my dietitian or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient Signature Date

INTAKE FORM REVIEWED BY: _____
Signature of Dietitian

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