

Michelle Kowalski M.S, R.D. CDN

1261 Ralph Street
Seaford, NY, 11783
(516) 817-2735

14 South Maryland Ave.
Port Washington, NY, 11050
(516) 767-3636

MEDICAL HISTORY

Name: _____ Date: _____

Address: _____ Age: _____ D.O.B: _____

Town: _____ Zip: _____ Occupation: _____

Sex: _____

Phone (home): _____ Mobile: _____

Office: _____

Education (circle the highest): High school College Graduate Degree

Marital Status: Single Married Divorced Widowed Separated

Living With: Family Friends Alone # of Persons in Household _____

Of Children in Household: _____ Ages of Children: _____

Primary Care Physician: _____

Address: _____

Date of Last Medical Check-up: _____ Last Date Blood Work Was Drawn _____

Past Hospitalizations: _____

Height: _____ Weight: _____ Usual Weight: _____

What do you want your ideal weight to be? _____

Family Medical History: (Ex: Diabetes, Cardiac, Cancer) _____

Do you have bowls movements daily? _____ How many a week? _____

Personal Medical History: Check problems you have or that have been diagnosed by a physician or other health professional.

Alcohol/ Substance Abuse

Anemia

Food Sensitivity

Lactose Intolerance

Other Allergies

Arthritis

Cancer

Diabetes

Heart Attack or Stroke

High Blood Pressure

Hypercholesterolemia

Chewing Difficulties

Gallbladder Disorder

Gout

Gastrointestinal Trouble

Constipation

Frequent Diarrhea

Obesity

Eating Disorder

Sleeping Problems

Ulcer

Limitations on Activity

Seeing, hearing, or other impairments: _____

Other: _____

Medications (Include nonprescription drugs, aspirin, laxatives, antacids, oral contraceptives, estrogen): _____

Vitamins/Herbs (Strength/Amt): _____

Smoker? Yes No If yes how many packs per day? _____

Regular Exercise (List activities and times per week): _____

Stress Level: Self-Assessment of stress level: High Moderate Low

Personality Type: Impatient, time oriented, competitive

Usually somewhat relaxed, sometimes anxious

Relaxed, easy going

Severe Personal Problems in the past 12 months (Such as death of a family member, marital problems, job change, lawsuits, serious family issues, etc.): _____

Why are you visiting a nutritionist today? _____

If you are seeing the nutritionist for weight loss answer the following questions:

What is your typical challenge when starting or following through on a weight loss plan? _____

Have you ever been on a weight loss plan before? Yes No Last 2 diets _____

Date: _____ If yes how much weight did you loose? _____

How long was the weight maintained? _____ What is most important to you regarding weight loss, what do you want to achieve being a thinner person or why do you want to be thinner? _____

Meal Plan History? What did you eat yesterday? List Water/Coffee/Tea/Diet Coke
Do you drink Water/Coffee/Tea/Diet Coke in between meals? _____

Please Note Beverage amounts: _____

Breakfast:	Snack:	Beverages:	Other:
Lunch:	Snack:	Beverages:	Other:
Dinner:	Snack:	Beverages:	Other:

