MEDICAL NUTRITION ASSESSMENT

PERSONAL INFORMATION
Living status:  ☐ Single  ☐ Married  ☐ Divorced  ☐ Widowed  ☐ Separated  ☐ Living with a partner
What medical condition are you here for? ________________ When were you first told about this condition? ________________
Have you had nutrition education about this condition in the past?  ☐ Yes  ☐ No If yes, what year? ________________
Do you have any cultural or spiritual practices of which you would like to make us aware that would impact the treatment/education plan we would provide to you?  ☐ Yes  ☐ No
If yes, please explain: ____________________________________________________________________________________

GENERAL HEALTH HISTORY
Please tell us the date of your last: Complete physical exam by your primary care doctor ___/___/___
Specialists (___________) ___/___/___ Specialists (___________) ___/___/___
Height ___’ _____”  Weight (lb) ______  Usual Body Weight (lb) ______
Hospitalizations/surgeries in last five years (date/reason): ______________________________________________________________________________________
Are you pregnant?  ☐ Yes  ☐ No  Are you considering pregnancy?  ☐ Yes  ☐ No
Please check all that apply and explain.
☐ Eye or vision problems _____________________________  ☐ Dental or mouth problems _____________________________
☐ Sleep apnea  ☐ Problems with sleeping _____________________________
☐ Changes in appetite/weight _____________________________
☐ Frequent (circle) nausea, vomiting, constipation, or diarrhea _____________________________
☐ High blood pressure  ☐ Stroke  ☐ Heart disease  ☐ High cholesterol/lipids/blood fats
☐ Foot problems _____________________________  ☐ Numbness/pain/tingling in feet _____________________________
☐ Circulation problems _____________________________  ☐ Open sores on skin _____________________________
☐ Thyroid disease _____________________________  ☐ Kidney/bladder problems _____________________________  ☐ Liver problems _____________________________
☐ Feelings of tiredness/weakness  ☐ Depression  ☐ Problems with sexual function _____________________________
Other problems _____________________________
Do you smoke?  ☐ Yes  ☐ No  If yes, how much per day? _____ would you like information on quitting?  ☐ Yes  ☐ No
Do you drink alcohol?  ☐ Yes  ☐ No  If yes, how much per day? _____________________________
Do you take street drugs?  ☐ Yes  ☐ No  If yes, please explain _____________________________
During the past month:
1. Have you often been bothered by feeling down, depressed, or hopeless?  ☐ Yes  ☐ No
2. Have you been bothered by little interest or pleasure in doing things?  ☐ Yes  ☐ No
3. Are you involved in therapy with a counselor or psychologist?  ☐ Yes  ☐ No
MEDICAL NUTRITION ASSESSMENT

NUTRITION/DAILY ROUTINE

What food planning methods have you followed in the past? (check all that apply)

- Calorie counting
- Exchange lists
- Food pyramid/healthy choices
- Low carbohydrate
- Carbohydrate counting
- Fat gram counting
- No added sugar
- No method
- Plate method/portion control

What method of meal planning (if any) are you currently using?

How often do you follow a meal plan?

- 0
- 1-25%
- 26-50%
- 51-75%
- >75%

Please fill in/circle the times of your meals and snacks, along with an example of the type and amount of food you might eat in one day. Example: Time: 3:00-4:00 PM  Typical Meals/Snacks: small bag potato chips, one bottle sweet iced tea

<table>
<thead>
<tr>
<th>My Usual Routine</th>
<th>Time</th>
<th>Typical Meals/Snacks for One Day</th>
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</thead>
<tbody>
<tr>
<td>I get up most days at</td>
<td>AM</td>
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<td>PM</td>
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</tr>
<tr>
<td>Breakfast</td>
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<td>PM</td>
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<tr>
<td>Morning snack</td>
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<td>Afternoon snack</td>
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<td>Evening meal</td>
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<tr>
<td>Bedtime snack</td>
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<td>I go to bed most days at</td>
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Food Preferences
- Vegetarian
- Ethnic
- Other

Food Allergies/Intolerances
- Yes
- No

What specific eating concerns do you have?
- Heartburn
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Loss of appetite
- Weight loss (losing weight without trying)
- Weight gain

ACTIVITY/EXERCISE

Has your doctor told you to limit your exercise in any way?
- Yes
- No

What kind of exercise do you do?
- Walking
- Biking
- Swimming
- Aerobic machine
- Sports
- Active job
- Other

How many times per week do you exercise?
- 0
- 1-2
- 3-4
- 5-6
- >6

How many minutes do you exercise each time?
- 0
- 1-15
- 15-30
- 30-45
- 45-60
- >60

What time of day do you exercise?

LIFESTYLE AND BEHAVIORAL CONCERNS THAT MIGHT AFFECT MY ABILITY TO TAKE CARE OF MYSELF

Check all that apply.
- Financial issues
- Language barriers
- Coping issues
- Depression
- Insurance issues
- Mobility issues
- Family life/home issues
- Transportation issues
- Job issues/work schedule
- Too busy to manage my health

What do you feel are your most important concerns in managing your health?

What would you like to learn during your visits?

PAIN

If you are in any kind of pain TODAY, please rate your pain on a scale of 1 (low) to 10 (high) and provide details.

Pain level _____  Details ____________________________________________________
MEDICATIONS: If you’ve **NOT** been a patient at GBMC since October 1, 2016, please list all current medications.

Medication allergies and reactions (please list): __________________________________________________________

**CURRENT MEDICATIONS** (include over-the-counter and herbal medications)

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>DOSE/FREQUENCY</th>
<th>REASON</th>
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Educators Name | Initials | Date |
---             |         |      |

Provider Reviewing this form with Patient: ___________________________________________________________