

# *Pelican Bay Nutrition*

## **Nutrition and Health History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Has your weight changed in the past 5 years? Yes or No (if yes please explain)

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At what weight have you felt most healthy? \_\_\_\_\_

What are your nutrition goals?

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What are the main topics you would like covered in your appointment?

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Please list 1-2 things you would like to change about your eating habits and briefly explain why?

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Are you currently, or have you ever, been on a special meal plan or seen a Registered Dietitian for nutrition counseling? Yes or No (if yes please explain)

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Is it OK to contact you by phone and/or email? Yes or No

If yes, please provide contact info:

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Medical History** *(Check any that apply)*

Anemia	High Blood Pressure	Food Allergies
Cancer	High Cholesterol	_____
Circulatory Problems	Liver Disease	_____
Diabetes	Kidney Disease	Surgery:
Prediabetes	Lung Disease	_____
Metabolic Syndrome	Arthritis	_____
Hypoglycemia	Osteoporosis/penia	Other: _____
Heart Disease	Stroke	_____

Please list all medications:

\_\_\_\_\_

\_\_\_\_\_

Please list all nutritional supplements and meal replacements:

\_\_\_\_\_

\_\_\_\_\_

Do you exercise? Yes or No (If yes briefly describe your exercise program below)

\_\_\_\_\_

\_\_\_\_\_

Do you smoke or use tobacco? Yes or No

Do you drink alcohol? (please circle) Never Rarely Monthly Weekly Daily

Is there anything you think I should know about you to better help you during this appointment?

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\_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

