METHODIST PHYSICIANS CLINIC

NUTRITION ASSESSMENT

PATIENT INFORMATION

Name: _____ D.O.B._____Today's Date:_____

Level of Education: _____Marital Status (circle): Single Married Widowed Divorced

Occupation: _____ Work Hours:_____

Provider's Name:_____

MEDICAL HISTORY

Lab results (list any that you know)

Total Cholesterol: _____ LDL: _____ HDL: _____ Triglycerides: _____

A1C:_____ (date:_____) Blood Pressure: _____(date:_____)

List any medical conditions:_____

_____

Smoking History: ☐ Never Smoker ☐ Former Smoker ☐ Current Smoker __

Medication	Amount in My Dose	Times Taken	Reason for Taking

List any family history of diabetes, heart disease, high blood pressure or obesity_____

_____

LIFESTYLE HABITS

Height: _____ Weight: _____

Did you have any weight changes in the last year? ☐ No ☐ Yes Increased weight #_____ Decreased weight #_____

Do you exercise? ☐ No ☐ Yes If yes, what type?_____

How many days per week?_____ How long each time? _____ Ok's by provider? ☐ Yes ☐ No

Do you have any food allergies or food intolerances? ☐ No ☐ Yes If yes, please list these foods:_____

_____

Do you follow any special diet? ☐ No ☐ Yes If yes, please list special diet:_____

_____

Do you skip meals? ☐ No ☐ Yes If yes, which meals?_____ How often?_____

Do you drink alcohol? ☐ No ☐ Yes If yes, number of drinks: ☐ per week or ☐ per day is = _____

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Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

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Do you eat out? ☐ No ☐ Yes If yes, how often?_____ Where?_____

Who does the cooking? _____ Who does the grocery shopping? _____

In the space provided, record what you typically eat including type and amount of food.

Example:	*Cereal-Cheerios - 1 Cup* *Milk – Skim - 1 Cup* *Toast - 2 slices*
Meal Times	**Food Eaten and Amount**
Breakfast Time_____	
Snack Time_____	
Lunch Time_____	
Snack Time_____	
Dinner Time_____	
Snack Time_____	

Patient Label

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