

Timely Access to Specialty Physicians

Appointments with Trusted Providers

nodSpecialists

2375 E Camelback Road Ste 600
Phoenix, Arizona 85016
602-551-8052
602-428-7025 (fax)
www.nodMD.com

NUTRITION ASSESSMENT

Name: _____

DATE OF BIRTH: _____ HEIGHT: _____ Ft. _____ Inch

Occupation: _____

Body Weight (if known): _____

How often do you weigh yourself? 1-3/day daily weekly monthly never

What do you consider your healthy weight? _____

Why? _____

What was your highest adult weight? Date: _____

What was your lowest adult weight? Date: _____

What prompted you to make an appointment to seek Medical Nutrition Therapy?

- 1.
- 2.
- 3.

What Are Your Goals for Medical Nutrition Therapy:

- 1.
- 2.
- 3.

MEDICAL AND NUTRITION HISTORY

List Medical History:	
Do you have family history of diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No; If yes, list closest relatives
Do you have family history of heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No; If yes, list closest relatives

Please list all medications you are currently taking:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please list all the dietary supplements, vitamins/minerals, or herbs that you are currently taking (and dose):

1. What was the date of your last medical doctor's visit?	Date:
2. How often do you see your doctor?	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually
3. Have you had your bone density measured?	<input type="checkbox"/> No <input type="checkbox"/> Yes date:_____
	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis
4. Do you smoke cigarettes?	<input type="checkbox"/> Yes ____ packs/day <input type="checkbox"/> No
5. Do you drink alcohol:	<input type="checkbox"/> Yes <input type="checkbox"/> No How many servings per day:
6. Do you use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Do you suffer from constipation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you suffer from chronic diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. If you answered yes to either # 7 or 8, how do you manage these conditions?	
10. Do you restrict how much you eat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Do you have a history of an eating disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Do you follow a specific number of calories per day?	Calories:
13. Do you exercise or do activities regularly to maintain your health?	<input type="checkbox"/> Yes <input type="checkbox"/> No; List types:
14. How often do you exercise?	<input type="checkbox"/> daily <input type="checkbox"/> 1-3x/week <input type="checkbox"/> 1x/week <input type="checkbox"/> never Duration:
15. Are you a vegetarian: <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Please check items excluded in your dietary intake: <input type="checkbox"/> Fish <input type="checkbox"/> Poultry <input type="checkbox"/> Eggs <input type="checkbox"/> Soy	
17. Do you have any food allergies or intolerances? <input type="checkbox"/> Yes <input type="checkbox"/> No - Explain:	
18. Food Dislikes:	
19. Favorite Foods:	
20. How many meals do you eat per day? <input type="checkbox"/> 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 3+	
21. Do you drink soda (diet or Regular) or sugar-containing beverages: How many daily:	

****Please provide copies of your recent laboratory values prior to your appointment. CMP/BMP, Lipid panel, HgA1C and Glucose if available.**