Personal Nutritional History

Date: _____

Name: _____ Male
First Middle Last Female

Birthdate: _____ Please circle one: Single / Married / Common Law / Separated / Divorced / Widowed

Name of Person Legally responsible: _____
(If patient is a minor, please state name of parent or guardian)

Home Address: _____
Street City Province Postal Code

Home Phone: _____ Cell Phone: _____

Employer: _____Occupation:_____

Business Phone: _____ Email Address:_____

Name of Spouse: _____ Alberta Health Care #_____

PAYMENT IS DUE AT TIME OF VISIT
Name of person responsible for payment: _____
Who may we thank for the referral? _____

Your Health History
Give the primary reason you are consulting with our doctor. Be sure to give a detailed account, including when and why it started, what has been done to date, the results you have had, and if the problem is getting better, worse, or is the same.

_____
_____
_____
_____
_____

Give any secondary health problems you are experiencing. List the most severe first.

_____
_____
_____
_____
_____

Have you been treated by a physician in the last year for any health concerns? YES / NO
Describe:_____
_____
_____

What do you hope to enjoy more or do better with improved health?

_____
_____

List all nutritional supplements you are taking. We ask that you bring all bottles to your consultation. *(If you need additional space please attach a sheet or use back of form)*

Supplement **Company** **Amount** **Reason for taking** **How long**

List all drugs (prescription/not) you are currently taking followed by other drugs taken in the past.

Name **Amount** **Reason for taking** **How long** **Results**

List all surgeries you have had, include the date, reason and results.

Surgery **Date** **Reason** **Results**

List all allergies you have to food, drugs, or other substances.

Allergy **Symptoms** **How long**

<u>Answer the following questions to the best of your ablility.</u>

My mother was healthy while pregnant with me. *Yes* *No*

If no, descibe: _____

Was your birth natural? *Yes* *No* If no, please circle: *anesthesia* *forceps* *c-section*

Were you breast fed for at least the first 6 months? *Yes* *No*

Were you fed anything other than breast or formula milk in the first 6 months? *Yes* *No*

List:_____

Were you a colicky baby? *Yes* *No* Until what age? _____

Have you ever been or lived in a foreign country? List: _____

Have you ever fainted or had a convulsion? Decribe: _____

_____

<u>Circle any you have had</u>:

Chicken Pox
German Measles
Hepatitis
Herpes
HIV/AIDS
Lymes Disease
Measles
Mononucleosis
Mumps
Rheumatic Fever
Scarlet Fever
Shingles
Venereal Disease: _____

Diet History:

water _____ /day coffee _____ /day juice _____ /day
alcohol _____ /day soda _____ /day other: _____

List your 10 favorite foods or foods eaten most frequently:_____
_____
_____

Give percentage for each of the following 3 questions (*total for each question should be 100%)*

- Where daily diet is prepared: ____ home ____ restaurant
  ____ fast food ____ vending machine
- How food is prepared: ____ baked ____broiled ____boiled ____ fried
  ____ steamed ____ microwaved ____ grilled ____raw
- Food prepared from: ____fresh ____ canned ____ frozen ____ prepackaged

Circle all that apply:

- My appetite is: *normal excessive poor none*
- I crave: *sweets salt chocolate water dirt other*: _____
- Water used for drinking/cooking: *tap/city spring well rain bottled distilled bottled filtered reverse osmosis*
- If purchased water, is it in: *soft plastic hard plastic glass*
- Foods that disagree with you: *raw vegetables raw fruit fats fried beans sugar milk/dairy greasy eggs onions cabbage highly spiced other:*_____

What symptoms do you get from foods that disagree with you?
_____
_____

Do you fast? If yes, how often and for how long? _____

Have you ever done a detoxification program? *Yes No* Details:_____

Circle any of the following diets you have tried:

All energy	High protein	Renal/ kidney
Atkins	High fiber	Ulcer
Complex carbohydrates only	Low cholesterol	Weight loss:_____
Diabetic	Low fat	Other:_____
Diverticulitis	Low purine	
HCG	Low salt	

What is your current weight and height? _____ Most ever weighed? _____

At what weight do you feel best? _____

Has your weight changed by more than 5 pounds in the past 6 months? *Yes No*

If yes, how much?_____

Exercise: How many days per week: _____ *minutes per day*:_____ t*ype*:_____

Bowel Health (BM = Bowel movement or stool)

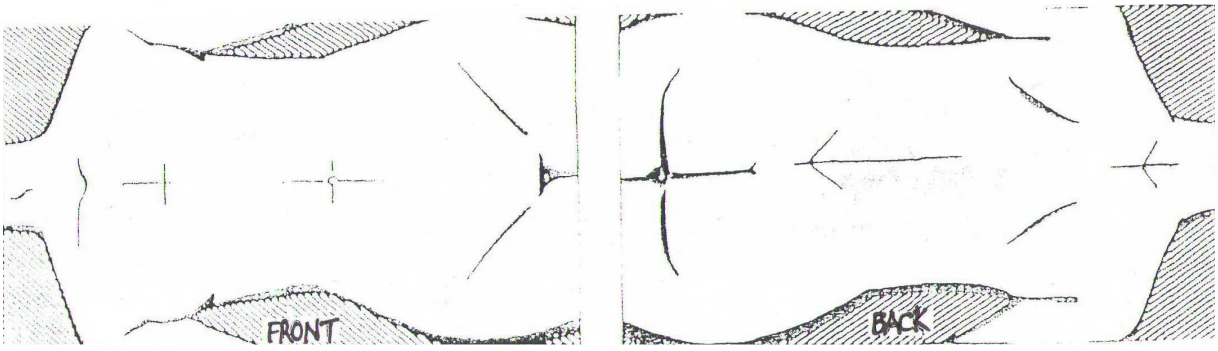
- How often do you have a BM: _____*times / day* _____*times / week*
- Do you use laxatives: *Yes* *No* *If yes, how often?* _____
- Do you get the urge to have a BM: *Yes* *No*
- Do you have pain with BM: *Yes* *No*

Answer key for the following: 0=never 1= rarely 2= frequently 3= always

Stool size	**Stool consistency**	**Stool color**
___ 2"wide & 6" length	___ float like a submarine	___ med/dark brown
___ 1"wide & 4+" length	___ float on top of water	___ very dark / black
___ thin, long or narrow	___ sink to bottom	___ yellow/tan/clay
___ large, hard	___ loose but not watery	___ greenish
___ difficult to pass	___ diarrhea	___ blood is visible
	___ alternate hard / diarrhea	___ mucous in / around

- Have you ever had worms or parasites? *Yes* *No* Treatment:_____
- Do you presently have rectal itching? *Yes* *No* When: *day* *night* *continuously*

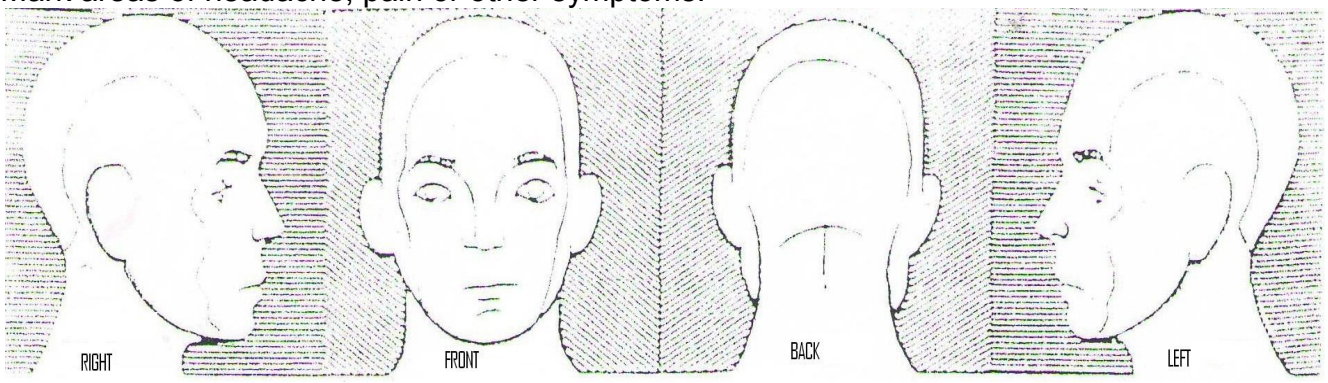
Digestion
Mark any areas of distress associated with food intake on the diagrams.



Circle all that apply:

- I experience: *indigestion* *belching* *heartburn* *stomach pain*
  excessive intestinal gas *bloating* *belching* *GERD*
- I experience an increase of these symptoms:
  before eating *immediately after eating* *1-2 hours after eating*
  3-5 hours after eating *6+ hours after eating* *no association with eating*
  morning only *afternoon only* *evening only constant*
- My intestinal gas has: *no odor* *slight odor* *very foul smelling odor*

Head, mouth and throat
Mark areas of headache, pain or other symptoms.



Circle all that apply:

- My teeth are: *good some fillings (amalgam or other) root canal some missing all missing*
- I wear dentures: *upper lower partial crown more than 1 metal type in mouth*
- My breath is: *good slight odor odor off/on offensive odor usually*
- My tongue is: *covered with small taste buds sore red blotchy pink with red tip*
- My tonsils are: *normal removed at age ___ enlarged spotted*
- My sense of taste is: *normal poor no taste oversensitive to: _____*
- My lips are: *normal dry peel a lot fever blisters often cracked corners*
- I get headaches: *daily weekly rarely never in the morning at night different types with some foods or drinks with weather with hormone changes with aura with nausea/vomiting*

Muscles, ligaments, joints and nerves (Circle all that apply)

- I have pain in: *neck mid-back low back hip knee ankle feet shoulder elbow wrist hands other: _____*
- I get: *swollen joints sore joints joints pop or crack leg cramps at rest leg cramps with activity worse at night flat feet burning feet tingling in hands or feet restless leg syndrome*
- I have: *nervous tic or twitching (area of body affected)*: _____ *Bell's Palsy ringing in ears Parkinson's Sciatic neuritis Multiple Sclerosis had spinal surgery (location and results): _____*

Hair, nails and skin (Circle all that apply)

- Hair: *course fine falls out excessively oil dry gray at age _____*
- Male Beard: *heavy light sparse none Ethnic background _____*
- Female only: *facial hair always facial hair (began at age:___) hair on abdomen/breast*
- Finger nails: *normal brittle / break easily soft ridged vertically white spots grow fast ridged horizontally grow slow shaped oddly hangnails*
- Skin: *normal oily dry flaky acne psoriasis boils small bumps on upper arms skin cancer removed on_____ antibiotics for acne at age _____ How long taken? _____*
- Spots on skin: *warts moles small red large red brown white*
- Hands and Feet: *ingrown toenails fungus on feet or nails athlete's foot*
- Dry cracked or bleeding areas on: *hands heels feet*

Chest and heart (Circle all that apply)

- I have chest pain that is: *sharp dull severe radiates to my arm, neck or back worse at rest worse on exertion better with exercise no changes with exercise*
- My pulse/heartbeat is: *too fast too slow skips beats*
- I have: *high blood pressure low blood pressure*
- I have had: *a heart attack bypass surgery angioplasty a stroke aneurysm*
- I have been told I have: *heart disease lung disease clogged arteries*
- I have: *varicose veins spider veins hemorrhoids had vessel surgery*

Respiratory, lungs and allergies (Circle all that apply)

- I have nasal congestion: *daily several times per week only on occasion*
- I have nasal discharge: *daily several times per week only on occasion*
- Appearance: *clear yellow green blood tinged other :_____*
- I have: *non productive cough (without mucus) productive cough (with mucus) hoarseness of voice post-nasal drip hay fever asthma wheezing snoring allergies: _____*
- I have/had: *frequent colds flu once or more times per year pneumonia sinus infections antibiotics 3 or more times in my life*
- I take: *allergy shots decongestants nasal sprays steroids*
- I use: *cigarettes ____/day snuff/chew cigars exposed to 2nd hand smoke*
- I have been told I have: *lung disease: _____ emphysema COPD*

Emotional, nervous and metabolism (Circle all that apply)

- I am / have: *nervous anxious depressed sensitive to noise fatigue easily confused easily sleepy during day exhausted a lot loss of appetite rage hear voices fearful weakness poor memory irritability morbid thoughts*
- I am / have: *suspicious of others thoughts of suicide quick mood changes fear of insanity fear of serious disease like:*_____ *avoid crowds friends avoid me have hypoglycemia / low blood sugar*
- Results of glucose tolerance test (if taken): *positive negative*
- I have: *daytime naps too many dreams no dreams have nightmares*
- I feel / have: *tired when I wake cold when others are comfortable too hot cold hands cold feet too much perspiration inadequate perspiration with* exercise
- Do you feel well rested when you wake up in the morning? *Yes No*
- Rate the quality of your sleep: _____ (1 being awful and 10 being great)
- Sleeping problems: *none getting up falling asleep staying asleep*
- How many hours of sleep do you get per night? _____

Female specific (Circle all that apply - Males, please go to next page)

- Age of first period: _____
- My menstrual periods are: *normal painful first day painful before and during flow is excessive have clots or hemorrhage flow is scanty*
- My cycles are: *regular every ___ days irregular no period in ___ months two or more per month abnormal since ___ years of age menstrual problems before first child menstrual problems after first child weight gain after first child weight gain after 2nd or 3rd child*
- Menstrual blood is: *pink red brown black other* _____
- I have / have had: *endometriosis constipation with periods diarrhea with periods*
- Organ drop: *uterus in position uterus out of position bladder prolapsed*
- I am / have been: *on birth control type:*_____ *total years on BCP* _____ *menopause at age* _____ *hysterectomy at age* _____
- I am on hormone replacement: *estrogen progestin oral patch implant wild yam cream bio-identical formulation*
- I have breast soreness: *before period during period after period all month long*
- I have / had: *fibrocystic breast breast cancer produce milk but not pregnant / nursing*

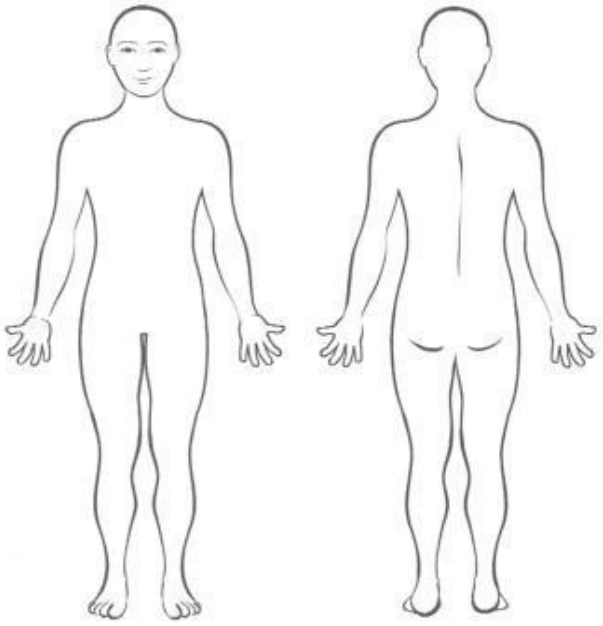
- My breasts are: *firm soft and saggy have implants had reduction surgery*
- I have: ____*children been pregnant ___times like children dislike children want more don't want more am infertile have fear of pregnancy*
- I get: *bladder infections yeast infections yeast infections after antibiotics*
- I get: *vaginal itching / burning inside / outside vaginal dryness painful intercourse*
- I urinate: ____ *times per day* ____ *times per night more frequent than normal with pain with difficulty starting/stopping with itching or burning*
- My urine is: *pale yellow bright yellow dark yellow other* _____ *clear cloudy with mucus varies a lot odor (if yes, describe):* _____
- I have / had: *venereal disease genital herpes herpes 1 HIV / AIDS*
- Libido (desire for sexual relation): *normal excessive increased diminished absent*

Continue on diagram on next page

Male specific (Circle all that apply)

- I am: *overly tired exhausted getting too old for anything impotent*
- My prostate: *normal enlarged had cancer removed*
- Date of last prosatate exam: _____
- Date of last blood PSA:_____ Result (number) _____
- I have: *pain on urination difficulty starting flow difficulty stopping flow dribbling of urine decreased stream size pain or pressure after sex get up to urine at night (____ times per night) burning discharge*
- My urine is: *pale yellow bright yellow dark yellow other* _____ *clear cloudy with mucus varies a lot odor (if yes, describe):* _____
- I have / had: *venereal disease genital herpes herpes 1 HIV / AIDS*
- I have/ had a hernia: *Yes No* Location: _____
- Pain in: *testicles scotum*
- Libido *(desire for sexual relation): normal excessive increased diminished absent*

ALL PATIENTS: Use the diagram to mark all areas of pain or discomfort you have experienced in the past 90 days. Describe your pain / discomfort in the margins and connect with arrows to each area the description applies to.



Are you currently seeing any other health care professional such as dentist, massage therapist, acupuncturist, psychologist, etc? Please explain:

Please fill out your family health history on the chart below.
Put an "N" in the box if you have it now, or a "P" if you have had it in the past.

	Alcoholism	Allergies	Alzheimer's	Arthritis	Asthma	Atherosclerosis	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	High blood pressure	Kidney Disease	Obesity	Osteoporosis	Sinus Problems	Stroke	Thyroid Problems	Tuberculosis	Ulcers
You																				
Spouse																				
Children																				
Mother																				
Father																				
Maternal Grandparents																				
Paternal Grandparents																				
Sisters																				
Brothers																				

Use this space to add anything else you would like to share about your health concerns that you think the doctor should know:

Please review this form to be sure your answers are accurate and sign below. Thank you for choosing our clinic. We look forward to working with you on your health goals.

Signature_____Date_____