# Nutritional Direction, P.A.

Name: ______________________________________________________________ Date: ___________________
Last First Middle Initial

**Family History of Illness & Disease**

| | |
|---|---|
| Mother: | |
| Father: | |
| Brothers/Sisters: | |
| | |
| Maternal Grandparents: | |
| | |
| Paternal Grandparents: | |
| | |
| Diagnosed illnesses/ diseases you've had: | |
| | |

**Blood Chemistry**

| Blood Pressure | Blood Type | Cholesterol Total | HDL | LDL | Triglycerides |
|---|---|---|---|---|---|
| | | | | | |

**Prescription Medicines (Please bring with you any supplements, i.e., vitamins, etc. that you are taking.)**

| List any prescriptions you are taking and for how long: | | | |
|---|---|---|---|
| | | | |
| | | | |

**Over-the-counter Medicines (Please bring with you any supplements, i.e., vitamins, etc. that you are taking.)**

| List any over the counter meds you are currently taking | | |
|---|---|---|
| aspirin | Ibuprofen | other |
| antacids | other painkiller | other |

**Personal Habits & Preferences**

Do you smoke? ☐ Yes ☐ No If yes, how much and how long? ___________________________________________

Interested in quitting? ☐ Yes ☐ No

How much alcohol do you drink? ____________________ How many times per week/month? _____________________

Have you ever used recreational drugs? ☐ Yes ☐ No

If yes, when? ______________________ What? __________________________ How long? ______________________

| How many times **per day** do you use caffeine? | |
|---|---|
| Coffee: | Tea: |
| Soft drinks: | Diet soft drinks: |

How much water do you drink? ___________ (8 oz glasses/day) ☐ Tap Water ☐ Purified/filtered

| List any organs/glands removed and when: | | |
|---|---|---|
| Tonsils | Appendix | Thyroid |
| Adenoids | Uterus | Kidney |
| Gall Bladder | Ovaries | Other |

**Surgical History**

| Other Major Surgeries or hospitalizations & dates: | | |
|---|---|---|
| | | |
| | | |

**Female Only Responses**

Do you use birth control pills? ☐ Yes ☐ No If yes, how long? ________________________________________

Do you use hormone replacement therapy? ☐ Yes ☐ No If yes, what? __________________ How long? _______

Do you have menstrual irregularities? ☐ Yes ☐ No Do you have PMS? ☐ Yes ☐ No

| Have you ever been diagnosed with: | Date of diagnosis |
|---|---|
| Endometriosis | ____________________________________________ |
| Fibroid tumors/cysts | ____________________________________________ |
| Fibrocystic breasts | ____________________________________________ |

Do you have breast implants? ☐ Yes ☐ No Date of Implants? _____________________

| Pregnancies you've had? | How Many? | Your Age(s) |
|---|---|---|
| Live births | _____________ | ____________________________________ |
| Miscarriages | _____________ | ____________________________________ |
| Abortions | _____________ | ____________________________________ |

**Male Only Responses** PSA Level _______________ Date Last Checked ______________________

Last bone scan date to check for osteoporosis: _____________ Results? _________

**Allergies**

Do you have allergies? ☐ Yes ☐ No To what? ____________________________________________________

Do you take allergy injections? ☐ Yes ☐ No

**Sleep Habits**

Do you have trouble ***falling*** asleep? ☐ Yes ☐ No Do you have trouble ***staying*** asleep? ☐ Yes ☐ No

How many hours of sleep do you attempt to get each night? ______________________

**Energy/Stress**

What is your level of energy? ☐ Low ☐ Med ☐ High What is your level of stress? ☐ Low ☐ Med ☐ High

Occupation: _____________________________________________________________________________

How many hours do you work per week? _________ Do you travel? ☐ Yes ☐ No Days/year? ________

**Family Information**

| Child's Name | Age | | Child's Name | Age | |
|---|---|---|---|---|---|
| | | ☐ Adopted ☐ Biological | | | ☐ Adopted ☐ Biological |
| | | ☐ Adopted ☐ Biological | | | ☐ Adopted ☐ Biological |
| | | ☐ Adopted ☐ Biological | | | ☐ Adopted ☐ Biological |
| | | ☐ Adopted ☐ Biological | | | ☐ Adopted ☐ Biological |

Are you married? ☐ Yes ☐ No If yes, how many years? __________ Spouse's Name ______________________

**Childhood History**

Did you have chronic sickness as a child? ☐ Yes ☐ No Did you have mononucleosis? ☐ Yes ☐ No

What are one or two of the most significant traumatic health issues you can recall from you childhood?

_______________________________________________________________

☐ Physical ☐ Emotional

_______________________________________________________________

☐ Physical ☐ Emotional

Were there abuse issues in your family of origin? ? ☐ Yes ☐ No

If yes, what Kind(s)? ☐ Alcohol ☐ Sugar ☐ Physical ☐ Emotional ☐ Sexual ☐ Religious

**Recent Health History**

How often do you get colds & flu, bronchitis, sinusitis or other? _______________________________

When was the last time you had antibiotics? ______________________________

| Check all you now have or previously had – identifying chronic issues with an asterisk. | | | | | |
|---|---|---|---|---|---|
| Fingernail or toenail fungus | | Bladder/Kidney infections | | Body rash (boils, itchy skin, etc.) | |
| Athlete's foot | | Jock Itch | | Vaginal yeast infection | |

Have you been out of the USA in the last five years? ☐ Yes ☐ No If yes, where? ______________________

Do you have:

Sugar cravings? ☐ Yes ☐ No Carbohydrate cravings? ☐ Yes ☐ No Salt cravings? ☐ Yes ☐ No

Other cravings? ☐ Yes ☐ No If yes, what type? ________________________________

Do you exercise? ☐ Yes ☐ No If yes, what do you do and how often? ______________________

List the diets you've tried in the past. ____________________________________________

What weight would you like to be? ____________________ What is your body fat percentage? _____________%

Do you have panic attacks? ☐ Yes ☐ No Other seizures? ☐ Yes ☐ No

How many bowel movements do you have per day? _____________ Per week? _____________

Do you routinely have diarrhea? ☐ Yes ☐ No Constipation? ☐ Yes ☐ No Mucous in the stool? ☐ Yes ☐ No

Undigested food particles in the stool? ☐ Yes ☐ No What color is the stool (routinely)? ______________________

**Dental History**

Do you have:

Mercury fillings in your teeth? ☐ Yes ☐ No If yes, how many? ________ Crowns or bridges? ☐ Yes ☐ No

Root canals?? ☐ Yes ☐ No If yes, how many? ________ Other? ___________________________________