NEW YORK GASTROENTEROLOGY ASSOCIATES

Nutrition Patient Information

Personal Information

Full name: ______________________________
Last *First* *M.I.*

Birth date: ____________ **Age:** ______

Martial status: ____________ **Occupation:** ____________

Preferred gender pronouns (optional): ____________

Whom may we thank for referring you to our office? ____________

Nutrition History

Height: ______ **Current weight:** ____________

Have you gained/lost (circle one) weight in the past 6 months? ____________

If yes, how much? ____________ **Was this weight change intentional?** ____________

Do you regularly experience any of the following symptoms?

Nausea ______ Loss of appetite ______
Vomiting ______ Excessive hunger ______
Diarrhea ______ Excessive thirst ______
Constipation ______ Hypoglycemia ______
Gas/bloating ______ Heartburn/reflux ______

Do you drink alcohol? ____________ **If yes, how many drinks per week?** ______

Do you exercise? ____________ **If yes, how many minutes per week?** ____________

Please list any food allergies here: ______________________________

Do you follow any special type of diet? ____________

If yes, please describe the type of diet you follow, including foods you may restrict:

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Medical History

Are you currently being treated for any medical problem? ________________

Have you or a close blood relative ever been diagnosed with any of the following conditions?

	You	**Relative** (specify relationship)
Heart disease:	________	____________________
Diabetes:	________	____________________
Cancer (if yes, please specify):	________	____________________
Kidney disease:	________	____________________
Liver disease:	________	____________________
Autoimmune disease (if yes, please specify):	________	____________________
Osteoporosis:	________	____________________
Any nutritional deficiency (e.g., anemia, Vitamin D):	________	____________________
Depression:	________	____________________
Eating disorder (if yes, please specify):	________	____________________
Other (please specify):	________	____________________

Please list all prescription AND over-the-counter (OTC) medications you currently use:

____

____

Please list all vitamin, mineral and/or herbal supplements you currently use:

____

____

Please list any accidents/surgeries you have had in the past (with dates):

____

Is there anything else about your medical history you feel we should know?