Medical Nutrition Therapy Intake Form

Name: _____ Date of Birth: _____ Date of Appt: _____

Height: _____ Weight: _____ Weight goal, if applicable: _____

Weight history: _____ Recent weight gain/loss: _____

Past Surgeries (state type and year): _____

_____

Reason for consult: _____

Have you ever seen a dietitian before? _____

HEALTH HISTORY (please check all that apply):

	You	Family		You	Family
High Blood Pressure	_____	_____	Osteopenia/porosis	_____	_____
Heart Disease	_____	_____	Diabetes (Type____)	_____	_____
Hyperlipidemia	_____	_____	Pre Diabetes	_____	_____
Celiac Disease	_____	_____	Cancer	_____	_____
Chronic Constipation	_____	_____	Type _____		
Chronic Diarrhea	_____	_____	Thyroid Disorder	_____	_____
IBS	_____	_____	COPD/lung disease	_____	_____
Crohn's Disease	_____	_____	Other _____		
Ulcerative Colitis	_____	_____	_____		
Disordered Eating	_____	_____	_____		

LAB VALUES

Relevant Labs	Value	Date
LDL		
HDL		
Total Cholesterol		
Triglycerides		
Glucose		
HbA1c		
Other:		

Tri-City Medical Center
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MEDICATIONS/SUPPLEMENTS

Please list all medication you are currently taking.

Medication	Dosage/Usage	Reason

Please list all vitamins, minerals, and herbs you are currently taking.

Supplement	Dosage/Usage	Reason