Optimal Health Nutrition Counseling

1165 Imperial Drive, Suite 200 Hagerstown, MD 21740

www.cwchagerstown.com

Patient Information Questionnaire

Name: _____ **DOB**: _____ **Today's date**: _____

Reason for visit: _____

Primary Care Provider: _____

How did you hear about us?_____

List Allergies/Reaction: _____

_____

Current Medications (include any dietary supplements, weight loss pills, or herbal supplements):

_____

_____

_____

Occupation: _____

Daily Activity Level (circle one): Sedentary Semi-Active Very Active

Current Exercise Regimen: _____

Previous Dietary Regimens (Heart Healthy, Diabetic, Weight Watchers, Atkins, Paleo, etc.):

_____

_____

_____

Medical History: Please circle any of the following that apply to ***YOU***:

Anemia
Anxiety
Asthma
Autoimmune disease
Blood transfusion
Cancer (specify type)_____
Bruising/bleeding disorder
Blood clotting disorder
Chronic back pain
Congenital heart disease
Depression
Diabetes (specify type) _____
Drug/Alcohol use
Gallbladder disease
Gastric Reflux
Headaches/Migraines
Heart Attack
Hepatitis/Liver disease
High Cholesterol
High Blood Pressure
Infertility
IBS

Medical History (continued):

Obesity

Ovarian Cyst

Pneumonia

Polycystic ovaries

Psychiatric disease (OCD, panic attack, bipolar)

Pulmonary embolism

Seizure disorder

Skin Disorder (eczema, psoriasis)

Stroke

Thyroid disease

Tuberculosis

Other: _____

Surgical History: Include elective procedures & attach additional paper if needed

Date of Surgery:	Type of Surgery:
_____	_____
_____	_____
_____	_____

Family History: Please circle any of the following that apply to your FAMILY members:

Cancer

Cardiovascular Disease/ High Cholesterol/ High Triglycerides

Chronic Kidney Disease

Diabetes

Heart Attack/Stroke

High Blood Pressure

Personal Caffeine Use: No Yes

Type: _____

Amount per day: _____

Personal Alcohol Use: No Yes Former

Type: _____

Amount: _____

Frequency: _____