

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*:

Diabetes (specify type) _____

Drug/Alcohol use

Gallbladder disease

Gastric Reflux

Headaches/Migraines

Heart Attack

Hepatitis/Liver disease

High Cholesterol

High Blood Pressure

Infertility

IBS

Anemia

Anxiety

Asthma

Autoimmune disease

Blood transfusion

Cancer (specify type) _____

Bruising/bleeding disorder

Blood clotting disorder

Chronic back pain

Congenital heart disease

Depression

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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: _____

Providers Signature: _____ Date: _____