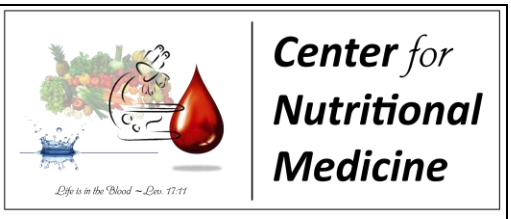
HISTORY AND PHYSICAL



Name _____ Date _____
Address _____ Occupation _____
Phone (home) _____ (cell) ___ Age _____ DOB: _____
Email:_____ Height: _____ Weight: _____

Diabetes: (**If diabetic**, check the one that applies to you and your medications - i.e. Type I children, Type II adults)

Type I - IDDM (Insulin) _____ ***Type I - IDDM (Pump)*** _____
Type II - IDDM (Insulin) _____ ***Type II - NIDDM (Oral)*** _____
Type II - NIDDM (Diet) _____ ***Hypoglycemic*** _____
Other Blood Sugar Handling Problems (IGT) _____

Current Treatment of diabetes:

MEDICATIONS:

Insulin: Type(s)_____ How many units _____
Time of Shot(s)_____

Pump: Basal rate _____ Bolus _____
Disetronic _____ Minimed _____ How long on pump _____

Oral (OHA's): Type(s): _____ How much_____
(Diabetes pills) Time of dosage _____

BLOOD GLUCOSE MONITORING:

How many times per day do you test? _____ Meter?_____
When do you test? Before breakfast _____ Before lunch _____ Before dinner _____
Before bedtime _____ Other _____

NUTRITION:
How many meals do you eat per day (when)?_____
How many snacks per day?_____When?_____
Are you currently on a meal plan (calorie exchange)?_____
(More specific information is required to assist us in accessing your nutritional status, please fill out the separate for on another form .)

EXERCISE:
Do you exercise?_____ When? _____ How long?_____
How often? _____What type?_____

COMPLICATIONS:

Have you experienced ketoacidosis and hypoglycemia over the past two years? What is the frequency and severity?

_____

_____

Have you had any prior or current infections, particularly skin, foot, dental, and genitourinary?

_____

_____

_____

Have you had any symptoms and treatment of chronic complications associated with diabetes in the following areas?

_____Eye
_____Kidney
_____Nerve
_____Heart
_____Foot
_____Gastrointestinal function
_____Peripheral Vascular (hands & feet)
_____Genitourinary (including sexual)
_____Bladder
_____Cerebrovascular (head)

Please explain_____
_____
_____

Other Medications

_____ _____
_____ _____
_____ _____
_____ _____

Please list any questions you have in regards to your diabetes:

_____
_____
_____
_____
_____

FAMILY HISTORY

	Self	Father	Mother	Grand-parents	Siblings	Children
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Gastrointestinal Disease	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Epilepsy/Convulsions	_____	_____	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____	_____

Comments: _____

_____

MEDICAL HISTORY

_____ Headache
_____ Hypertension
_____ Congenital Heart Disease
_____ Epilepsy
_____ Fatigue
_____ Shortness of Breath
_____ Heart Palpitations
_____ Allergies/Hay Fever
_____ Asthma
_____ COPD
_____ Claudication
_____ MI
_____ Stroke/TIAs
_____ Orthopnea
_____ Hyperlipidemia
_____ GU Disorder
_____ Arrhythmia
_____ Menstrual Dysfunction
_____ Bowel Irregularity
_____ Prostate Disease
_____ Liver Disease
_____ Ulcer
_____ GI Disorder
_____ Lactose Intolerance
_____ Renal Disease
_____ Rheumatic Fever
_____ Sexual Dysfunction
_____ Endocrine Disease
_____ Arthritis
_____ Osteoporosis
_____ Incontinence
_____ Venereal Disease
_____ Anemia
_____ Gout
_____ Scarlet Fever
_____ Congestive Heart Failure
_____ Heart Murmur
_____ Chest Pain/Angina
_____ Dizziness/Fainting
_____ Anxiety/Depression

Comments: _____

_____

HABITS

____ Smoke: Packs daily _____
____ Exercise
____ Food Allergies_____
_____
_____ Coffee: Cups daily _____
_____ Other Caffeine_____
_____ Alcohol _____
_____ Sleep: Difficulty falling asleep
_____ Continuity disturbances
_____ Snoring
_____ Early morning awakening
_____ Daytime drowsiness

Comments: _____

_____

OTHER COMMENTS:

How often do you see a physician?_____

Which types of practitioners participate in your overall healthcare? (i.e. doctor, nurse educator, dietitian, podiatrist, etc.)_____

_____

What diagnostic testing is part of your overall healthcare?_____

Have you ever received medical attention for a complication related to diabetes? (i.e. eyes, heart, feet, kidneys, heart, etc.) _____

_____

Did any complication lead to hospitalization?_____

_____

_____

Have you been tested for diabetic peripheral neuropathy? (feet)_____

Have you been referred to a different health care provider as a result of diabetic complications?__

Explain_____

_____

_____

Any other health concerns we should know about?_____

_____

_____

Center for Nutritional Medicine

Food History Questionnaire and Assessment

Name:_____ Date:_____

Occupation:_____

Height:_____ Weight:_____ Age:_____ Sex:_____

Have you ever tried to lose weight before? ☐ Yes ☐ No

Diet (specify)_____ Weight Change _____ How long did it last?_____

Diet (specify)_____ Weight Change _____ How long did it last?_____

Weight History: (list)

_____

Have you ever used laxatives for weight control? ☐ Yes ☐ No

Have you ever vomited for weight control? ☐ Yes ☐ No

Medications: (list)

_____

_____

_____

Have you ever been advised by your physician to follow any type of diet? (low salt, low cholesterol, no sugar, diabetic, etc.)_____

_____

What changes did you make at that time?_____

_____

Typical eating patterns:

How many days per week do you eat: Breakfast____ Lunch____ Dinner____

How often do you snack? _____ Once daily _____ Twice Daily _____Three times daily

When do you usually snack?_____

What do you snack on?_____

_____

Do you eat out? ☐ Yes ☐ No How often?_____

Which restaurant(s) do you usually choose?_____

_____

_____

Do you eat standing up? ☐ Yes ☐ No

Do you eat in the car? ☐ Yes ☐ No

Do you eat at the table? ☐ Yes ☐ No

Do you eat with others? ☐ Yes ☐ No

Do you set the table? ☐ Yes ☐ No

Do you engage in other activities when you eat? ☐ Yes ☐ No

Do you feel you eat fast? ☐ Yes ☐ No

Do you chew your food? ☐ Yes ☐ No

Do you hold conversation when you eat? ☐ Yes ☐ No

Who usually prepares the food at home?_____

Do you cook? ☐ Yes ☐ No

Do you **exercise**? ☐ Yes ☐ No

Type/Duration: _____

_____

Do you drink alcohol? ☐ Yes ☐ No

Number of beverages per week: _____

Who usually does the grocery shopping? _____

Do you read the labels? ☐ Yes ☐ No

What do you look for on the labels? _____

_____

Is there any member of your household on a special diet? ☐ Yes ☐ No

Does any member of your family have a health problem? _____

_____

Do you take any vitamin, mineral or food supplement? ☐ Yes ☐ No

Type(s) _____

Do you have any food allergies? ☐ Yes ☐ No

Specify: _____

What are your favorite foods? _____

_____

Would you like to change your eating habits? ☐ Yes ☐ No

If yes, please explain why? _____

_____

_____

_____