Health History and Nutrition Questionnaire

Name _____ Age ____ M/F Date _____

Personal Health Goals:

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Medical History (include dental problems):

Current Medications (include Supplements):

Main Health Problems in Family (Mother/Father/Siblings):

Laboratory Results (if available)

Bowel Function (discomfort in lower abdominal area/diarrhea/constipation) _____

Food Allergies/Sensitivities: _____

(Leave this column blank)

Sleep Patterns _____

Previous "Diets" (what/when): _____

Smoker Yes/No

Exercise History (frequency/duration/type):

Food Log (bring 2-day food log – approximate amount and time eaten) – don't change the way you eat for this exercise)