Patient Questionnaire

NAME :

ADDRESS:

EMAIL:

PHONE: H. W. M.

Your Current Weight:

Desired Weight:

Do You Exercise Regularly?

MEDICATIONS: Please list and state the condition for which they were prescribed:

ALLERGIES:

VITAMIN, MINERAL, HERBAL, HOMEOPATHIC SUPPLEMENTS:

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

DIABETES

KIDNEY DISEASE

LIVER DISEASE

HIGH BLOOD PRESSURE

HEART DISEASE

EPILEPSY

FLUID RETENTION

DIGESTIVE PROBLEMS

URINARY INFECTIONS

OTHER

PREVIOUS OPERATIONS

MAIN REASON FOR TODAY'S VISIT

DIET: Thinking about the last 3 days, what do you typically eat?

Breakfast:

Lunch:

Dinner:

How much alcohol do you drink?

How many soft drinks?

How much water?

Do you use artificial sweeteners? Which ones?

Do you smoke? How many per day?

Do you sleep well?

Anything else you would like to note?