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New Patient Health History Questionnaire

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influence by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. Please have this back to us at least 48 hours prior to your visit.

You may fax it 800 692-9711, or email gay@netnutritionist.net. If you have any questions please call 214 244-0429 or email me at gay@netnutritionist.net.

Name_____

Address:_____City:_____State:_____Zip:_____

E-mail Address: _____ Fax Number: (_____)_____-_____

Home Phone:(_____)_____-_____Work:(_____)_____-_____Cell:(_____)_____-_____

Birthdate____/____/_____ Age :_____ Place of Birth :_____

month day year city/town (and country if not in US)

Occupation: _____ Referred by: _____

Height:_____'_____" Weight: _____ Sex:_____ Today's date_____

1. Please list the main reason(s) for seeking nutritional advice? _____

_____

_____

2. Please **rank** current/ongoing problems **by priority** and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/SEVERE	TREATMENT	SUCCESS
Example: Diarrhea	Moderate	medication	Moderate
a.			
b.			
c.			
d.			
e.			
f.			

3. PAST MEDICAL AND SURGICAL HISTORY:

ILLNESSES	WHEN	COMMENTS
Anemia (type)		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, Convulsions or Seizures		
Gallstones		
Gout		
Heart Attack/Angina		
Heart Failure		
Hepatitis		
High Blood Fats (cholesterol, triglycerides)		
High Blood Pressure (hypertension)		
Irritable Bowel		
Kidney stones		
Mononucleosis		
Pneumonia		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Other (describe)		
INJURIES		
Back injury		
Broken Bones		
Head Injury		
Neck Injury		
Other (acute) ex: sprained muscle		
Other (chronic) ex: bad knees		
DIAGNOSTIC STUDIES		
Bone Scan		
CAT Scan		
EKG		
MRI		
Upper/Lower GI Series		
Other (describe)		
OPERATIONS		
Dental Surgery		
Gallbladder		
Hysterectomy		
Tonsillectomy		
Other (describe)		

4. Please indicate significant family medical history (ex: cancer, diabetes, heart disease, etc.)
Maternal side:_____

_____

Paternal side:_____

_____

5. Are your parents living? ❒No ❒Yes
If no, comment:_____

6. As an infant, were you: Breast fed?❒ Formula fed?❒
7. Did you have any health issues as a child? ❒No ❒Yes-What age?_____
Describe:_____

_____

8. What is your blood type?_____
9. As a **child,** were there foods you avoided? ❒No ❒Yes-(please specify below)

Food	Symptoms
Ex: Milk	Ex: Gas and diarrhea

10. Please mark in the chart below with information about recent bowel movements:

Frequency:		**Color:**	
More than 3 times a day		Dark brown	
2-3 times a day		Medium brown	
One time per day		Very dark or black	
4-6 times a week		Greenish	
2-3 times a week		Blood is visible	
Once or fewer a week		Varies a lot	
Consistency:		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose, but not watery			
Alternating between hard and loose/watery			

11. Do you experience intestinal gas? (check all that apply)
❒present with pain ❒ foul smell ❒ little odor ❒ excessive daily ❒ occasionally

12. Do you experience anal itching? ❒ frequently ❒ occasionally ❒ rarely ❒ never

13. Have you ever been pregnant? ❒No
❒Yes If yes, please answer the following:
a. Number of miscarriages:_____ b. Number of abortions:_____ c. Number of preemies:_____

d. Number of term births:_____ e. Birth weight of largest baby:_____Smallest baby:_____

f. Did you develop toxemia? ❒No ❒Yes
g. Have you had any other problems with pregnancy? ❒No ❒Yes
If yes, describe:_____

14. Age of first mensus:_____

15. Date of last Pap Smear:_____❒Normal ❒Abnormal

16. Date of last Mammogram: _____❒Normal ❒Abnormal

17. Do you currently use contraception? ❒No ❒Yes-(type)_____

18. Are you currently taking birth control pills? ❒No ❒Yes-(how long?_____)

If you're on the pill please comment on physical or mental changes from before taking:
_____
_____

19. Do you currently or have you experienced PMS (i.e. water retention, breast tenderness, irritability, etc.)?
❒No ❒Yes-(specify)_____

20. Are you in menopause? ❒No ❒Yes-(age of last period)_____

21. Do you take: ❒ Estrogen ❒ Testosterone ❒ Progeterone ❒ Other-(specify)_____

22. Do you have urinary problems? ❒No ❒Yes
If yes, please specify: ❒ Nightly urination ❒ Frequent day time urination ❒ Hesitancy
❒ Irregular ❒ Dribbling afterwards ❒ Frequent urge to urinate ❒ Difficulty
❒ Feeling of incomplete emptying ❒ Burning sensation

23. Do you have prostate swelling? ❒No ❒Yes

DENTAL:

24. Do you have amalgam (silver, black or grey) fillings? ❒No ❒Yes (how many?) _____

25. Have you every had fillings replaced?
❒No ❒Yes-(how many?)_____when?_____with what material?_____

26. Do you have root canals? ❒No ❒Yes (how many?) _____

27. Have you had any cavities in the last 2 years? ❒No ❒Yes (how many?) _____

28. Do your gums ever bleed? ❒No ❒Yes-(how often?)_____

29. Do you ever grind your teeth? ❒No ❒Yes

30. Do you have any artificial joints or implants anywhere in the body or mouth? ❒No ❒Yes

SOCIAL:

31. How well have things been going for you lately?:

	Great	Good	Could be better	Not very good	Does Not Apply
a. school					
b. job					
c. social life					
d. close friends					
e. sex					
f. your attitude					
g. boy/girlfriend					
h. children					
i. parents					
j. spouse					

32. With whom do you live? Describe.

_____

_____

33. What is the attitude of those close to you concerning your health?
❒Supportive ❒ Not supportive ❒ Indifferent

34. Are you currently married, or have you ever been married? ❒No ❒Yes
If yes, when _____ If still, spouse's occupation: _____

Have you been separated or divorced? If yes, when? _____
Are you remarried? _____ Additional comments: _____

35. What are your hobbies and leisure activities? _____

36. Describe previous jobs/work: _____

37. Have you lived outside of the United States? ❒No ❒Yes If yes, where/when? _____

38. What is your total amount of travel by airplane, in the last year? _____
Estimated total in life: _____

39. Have you or your **family** recently experienced any major life changes? ❒No ❒Yes
If yes, please comment: _____

_____

40. Have **you** experienced any major losses in your life? ❒No ❒Yes
If so, please comment: _____

_____

41. Have you ever had psychotherapy or counseling? ❒No ❒Yes
If yes, what kind? _____ when? _____
Additional comments: _____

_____

_____

LIFESTYLE:

42. How important is religion (or spirituality) to you?
❒Not at all important ❒ Somewhat important ❒ Extremely important

43. Do you meditate? ❒ occasionally ❒ often ❒ never

44. How much control do you feel you have over your current state of health? Rate 1-10 (none-all)_____
Comment:_____
_____

45. How much time have you lost from work or school in the past year due to illness?
❒ 0-2 days ❒ 3-5 days ❒ 6-14 days ❒ more

46. What is your usual bed time?_____wake time?_____

47. How well do you sleep?
❒Adequate-(sleep through the night) ❒ Wake up feeling well rested
❒Trouble falling asleep ❒ Wake up still tired
❒Trouble staying asleep-(How many times do you wake during the night?_____

48. Check off typical bedtime activities:
❒Watch television ❒ Read a book ❒ Listen to music ❒ Bed time snack
❒Meditate ❒ Bathe/shower ❒ Drink alcohol ❒ Drink caffeinated beverage
Other-(specify)_____

49. Do you ever need to take a sleep aid?
Which one(s)?_____
How often?_____

50. Do you exercise regularly? ❒No ❒Yes-(specify):
❒Once per week ❒ 2 times per week ❒ 3 times per week ❒ 4 times per week
Amount per session: ❒ less than 15 minutes ❒15-30 minutes ❒30-45 minutes ❒ > 45
❒Other-(specify)_____

51. What type of exercises do you do?
❒Jogging ❒ Walking ❒ Weight training ❒ Water sports ❒ Aerobics ❒ Yoga
Other-(specify)_____

52. Do you get sun exposure? ❒No ❒Yes-(specify) ❒ Daily ❒ Weekly How much? _____

53. Do you wear sun block? ❒No ❒Yes-(percentage of time)_____

ALLERGY & TOXIC POTENTIAL:

54. Do you have any pets or farm animals? ❒No ❒Yes

55. Where do they live? ❒ Indoors ❒ Outdoors ❒ Both
56. Do you have sinus problems? ❒No ❒Yes-(specify) When?
57. Nasal congestion? ❒No ❒Yes-(specify)
58. Itchy or watery eyes? ❒No ❒Yes-(specify)
59. Do odors such as perfume, cleaning solutions, smoke, etc. affect you? ❒No ❒Yes
If yes, explain:_____
_____
_____

60. Have you, to your knowledge, been exposed to toxic metals at your job or at home?
❒No ❒Yes: ❒ Lead ❒ Cadmium ❒ Arsenic ❒ Mercury ❒ Aluminum
Explain:_____

61. To your knowledge, have you ever been exposed to an ongoing amount of any of the following?
❒No ❒ Solvents ❒ Paints ❒ Pesticides ❒ Petrochemicals
❒ Coal ❒ Hydrocarbons ❒ Mold ❒ Other (specify):_____

62. Have past activities/hobbies exposed you to photography chemicals, paints, glues, or dyes?
❒No ❒Yes-(explain)_____
How often do you wear dry cleaned clothing? _____

63. Do you have a regular lawn care service? ❒No ❒Yes-(how often?)_____

64. Do you regularly spray for pests outdoors? ❒No ❒Yes-(how often?)_____

65. Do you use bug spray (outside) or insecticides (indoors) on a regular basis? ❒No ❒Yes

66. How often are you exposed to burning coal, bonfires, fire pits, etc.?_____

67. Do you consume alcohol regularly now or did you consume alcohol regularly in the past?
❒No ❒Yes- Currently: ❒1-3 drinks per week ❒4-6 ❒ 7-10 ❒ 10 or more
❒Yes- In the past: ❒1-3 drinks per week ❒4-6 ❒ 7-10 ❒ 10 or more
If you have quit, when?_____

68. Have you ever used tobacco? ❒No ❒Yes-(specify)_____
If yes, number of years:_____ Amount per day:_____ Year quit?_____

69. Are you now or were you ever regularly exposed to second hand smoke? ❒No ❒Yes When? _____

70. Have you ever used recreational drugs? ❒No ❒Yes-(specify)_____

MEDICATIONS & SUPPLEMENTS:

71. What medications are you taking now? Please also include non-prescription drugs you take **daily/regularly**.

Medication Name	Purpose	Dosage	Start Date
1.			
2.			
3.			
4.			
5.			
6.			

72. Do you take any other over the counter medications on an **occasional basis**?
If yes, which one(s)?_____
_____

73. Were you ever on antibiotics for a prolonged period of time? ❒No ❒Yes
If yes, explain:_____

_____

74. How many times have you taken antibiotics as an infant or child?
❒Less than 5 times ❒ More than 5 times ❒ More than 10 time ❒ So many times I lost count
Reason:_____

75. As an adult, how often do you take antibiotics?
❒Never ❒ Once a year (on average) ❒ 1-3 times a year (on average)
Longer-(explain)_____
Why?_____

76. Fill in the chart below for how many times have you taken oral steroids (e.g. Cortisone, Prednisone, etc.)?

	Less than 5 times	Greater than 5 times	Greater than 10 times
Infancy/Childhood			
Teen			
Adulthood			

77. List all vitamins, minerals, and other nutritional supplements that you are currently taking. Indicate unit (mg or IU), and form (for example: calcium carbonate vs. calcium lactate).

******Please bring bottles with you to your appointment******

Vitamin/Mineral/Supplement	Brand	Dosage	Start Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

DIETARY HABITS:

78. Are you currently on a special diet (i.e., vegetarian, South Beach, etc)? ❒No ❒Yes
If yes, describe:_____

_____

79. Usual Breakfast time:_____Lunch time:_____Dinner time:_____

80. How many cups (8 ounces) of water do you drink on a typical day?_____

81. Place a mark next to the food/drink that applies to a typical day of your current diet.

	Usual Breakfast		Usual Lunch		Usual Dinner
☐	None	☐	None	☐	None
☐	Cereal	☐	Eat in cafeteria	☐	Pasta
☐	Wheat Bran	☐	Eat in restaurant	☐	Potato
☐	Oatmeal	☐	Leftovers	☐	Brown rice
☐	Toast	☐	Meat sandwich	☐	White rice
☐	Bagel	☐	Fish sandwich	☐	Beans (legumes)
☐	Sweet roll	☐	Lettuce (on sandwich)	☐	Fish
☐	Donut	☐	Tomato	☐	Red Meat
☐	Eggs	☐	Salad	☐	Poultry
☐	Bacon/Sausage	☐	Salad dressing	☐	Salad
☐	Fruit	☐	Soup	☐	Salad dressing
☐	Yogurt	☐	Fruit	☐	Green vegetables
☐	Milk	☐	Yogurt	☐	Carrots
☐	Juice	☐	Milk	☐	Yellow vegetables
☐	Tea	☐	Juice	☐	Milk
☐	Coffee	☐	Tea	☐	Juice
☐	Water	☐	Coffee	☐	Tea
☐	Butter	☐	Water	☐	Coffee
☐	Margarine	☐	Regular soda	☐	Water
☐	Sugar	☐	Diet soda	☐	Regular soda
☐	Sweetener	☐	Butter	☐	Diet soda
☐	Leftovers	☐	Margarine	☐	Butter
☐	Oil	☐	Mayonnaise	☐	Margarine
☐	Nuts	☐	Sugar	☐	Sugar
☐		☐	Sweetener	☐	Sweetener
☐	Other:	☐	Other:	☐	Other:

82. How often and what portions do you eat of the following (ounces, cups, each, etc)?

Food	Amount Per Day	Amount Per Week
Candy		
Cheese		
Chocolate		
Cups of caffeinated coffee		
Cups of decaffeinated coffee		
Cups of hot chocolate		
Cups of tea (containing caffeine)		
Diet sodas (cans)		
Regular soda (cans)		
Ice cream		
Salty snacks		
Slices white bread/rolls/1/2 bagel		
Nuts		
Fish (what kind prepared how?)		
Oils (what kinds, how do you use them)		
Vegetables (list)		
Fruit (list)		
Frozen entrees (what kind)		

83. Do you currently or typically have any symptoms **immediately after** eating? (For example: belching, fatigue, bloating, sneezing, hives, etc.? ❒No ❒Yes If yes, are these symptoms associated with any particular food that you are aware of? Explain:(example: Milk-gas cause diarrhea)_____

_____

_____

84. Do you feel you have **delayed symptoms** after eating certain foods, such as: fatigue, muscle aches, sinus congestion, etc.? *Delayed symptoms may not be evident for 24 hours or more after eating.*
❒No ❒Yes
If yes, specify: _____

_____

85. Do you feel **much worse** when you eat any of the following: (check all that apply)
❒high fat foods ❒ refined sugar (junk foods) ❒ high protein foods ❒ fried foods
❒high carbohydrate foods ❒1 or 2 alcoholic drinks
❒ (breads, pastas, potatoes) ❒ Other (specify):_____

86. Do you feel **much bette**r when you eat a lot of: (check all that apply)
❒high fat foods ❒ refined sugar (junk foods) ❒ high protein foods ❒ fried foods
❒high carbohydrate foods ❒1 or 2 alcoholic drinks
❒ (breads, pastas, potatoes) ❒ Other (specify):_____

87. Do you feel **worse** at certain times of the year? ❒No ❒Yes-(when?_____)
How do you feel?_____

88. Do you feel **better** at certain times of the year? ❒No ❒Yes-(when?_____)
How do you feel?_____

89. Does skipping a meal greatly affect your symptoms? ❒No ❒Yes

90. Do you ever crave or "binge" on certain foods? ❒No ❒Yes
Which foods, how often and comment on possible stressors/triggers? _____

_____

_____

91. Do you avoid certain foods for any reason? ❒No ❒Yes
Which foods and why?_____

_____

91. How many times a day do you eat out in restaurants or take in?_____

92. What are your 3 most common convenience or restaurant foods? Please explain._____

_____

93. What are the same foods that you eat everyday?_____

_____

_____

94. Do you eat differently during the week than you do on weekends?_____

_____

Food Frequency List

Please indicate the **approximate number of times** you have eaten these foods in a typical week. For each section you may **cross out** food/beverages seldom consumed, and **circle** foods/beverages you do eat.

Consumed in the past 7 days	Number of Times	Consumed in the past 7 days	Number of Times
Vegetables: Dark green leafy: spinach, Romaine, leaf lettuce, Caesar Salad, etc.		**Fish: (list):** fresh, fried or canned?	
Iceberg lettuce or **bagged salad combos**, celery cucumbers, zucchini		**Poultry: Chicken:** dark meat, breast **Turkey:** dark meat, breast, lunch meat, turkey bacon	
Broccoli, Brussels sprouts, cabbage/coleslaw, kale, turnip or mustard greens		**Beef:** hamburgers, steak meatloaf, stew, chili Is it usually regular, lean, grass fed or organic?	
Fresh/frozen **mixed** veggies: corn, green beans, peas		**Pork:** ham, sausage, bacon	
Yellow-orange veg: carrots, squash, sweet potatoes		**Hot dogs:** beef or turkey, bratwurst, italian sausage, etc.	
Tomatoes, pasta sauce, tomato juice, V-8, salsa, etc		**Fried foods:** fries, chicken, etc.	
Fresh vegetable juices:		**Lunchables®, bologna, salami,** etc.	
Other: ORGANIC? ☐		**Vegetarian foods: (list):**	
		Indian Vegetarian foods: (list):	
Fruits: (check): banana☐ pear☐ apple☐ grapes☐ kiwi☐ **Other:**		**Beans, legumes, peas:** bean/lentil soup, bean burritos, veg chili, split pea soup, etc.	
Berries (list):		Vegetarian foods: (list):	
Canned/jar fruit: applesauce, pears, peaches		**Veggie burgers, TVP, tofu, tempeh, seitan, Quorn® products, etc.**	
Dried fruits:		**Raw nuts/seeds:** almonds, sunflower seeds, pecans, walnuts, etc.	
Wheat bread: rolls, buns, sandwiches, pita, bagel White, whole grain, low carb, spelt, Ezekiel®		**Trail mix**, roasted salted nuts	
Cold cereal (list):		**Peanuts**, peanut butter, **almond** butter, tahini, etc	
Hot cereal (list):		**Protein** powders: **soy**☐ **whey**☐ **egg**☐ **rice**☐	
Pancakes, waffles **tortillas**: corn or flour		**Protein:** liquid (ready-to-drink)	
Muffins, donuts, sweet rolls, granola bars		**Flax** seed meal or flax oil, **cod liver oil**?	
Pretzels, crackers, etc.		**Butter:** ORGANIC? ☐	
Gluten-free foods:		**Margarine: (list brand):**	
Rice:		**Potato chips**, Fritos®, Doritos®, Pringles®, etc.	
Potatoes: mashed☐ boiled☐ baked☐ Red☐ White☐		**Popcorn: prepackaged or homemade?**	
Pasta: spaghetti, lasagna, macaroni, pasta salad, etc.		**Candy (list):**	
		Pie, cake, cookies, other snacks (list):	
Eggs: whole☐ whites only☐		**Gum**, breath mints: regular or sugarless?	
Dairy: Cow's milk: skim☐ 2%☐ whole☐ **ORGANIC?** ☐		**Coffee/espresso drink**? Regular or decaf? # of 8oz cups?	
Yogurt, cheese, nachos, cottage cheese **ORGANIC?** ☐		**Tea:** black, green, white, herbal infusion.	
Pizza: sausage, peperoni, vegetable, etc.		**Sugar or no/low calorie sweetener? (list):**	
Ice cream, frozen yogurt, shakes, malts, etc.		**Soda pop: regular or diet? (list):**	
Soy milk, **goat** milk, **rice** milk, **almond** milk		**Alcohol** beverage: wine, beer, hard liquor	
Circle other frequent foods: Frozen/microwave meals: Weight Watchers®☐ Lean Cuisine®☐ Healthy Choice®☐ Mexican cuisine☐ Indian cuisine☐ Chinese/Thai☐ Vegetarian☐ Atkins®☐ Low carb☐ SlimFast®☐ Other:			
Average daily water intake in 8 oz glasses (not counting soda pop or coffee): 1-2☐ 3-4☐ 5-6☐ 7-8☐ 9-10☐ **Is it: tap water☐ filtered tap water☐ spring water☐ distilled☐ other☐ If filtered, how?**			

95. Please write down what you eat and drink on a typical day with the time/location.

Time:	Food or Drink:	Amount:	Where:

96. With whom do you usually eat your meals?_____
97. What do you usually do while you eat your food?_____
98. Are you the primary cook for the house hold?_____ If not who is?_____
99. Where do you usually grocery shop?_____
100. How many hours a day do you: Watch TV?_____Sit at the Computer? ____Drive?_____Exercise?_____Do household chores?_____Talk on the cell phone?_____ Talk on your cordless or wireless phone?_____Do you have a television in your bedroom?_____ Do you use wireless (Wifi) in your home?_____How many wireless devices do you have in your home?_____Do you sleep in a wood frame bed or a metal framed bed?_____Do you have an alarm clock next to your bed which is plugged in?_____What type of light bulbs do you use in your home?_____Do you live near electrical towers?_____Cell phone or radio towers?_____ An electrical transformer?_____Do you have a slab or pier and beam home?_____

101. Anything else you think we should know?

_____
_____
_____
_____
_____
_____
_____
_____
_____

102. Please provide us with any current lab results (within the last 3-6 months).

DISCLAIMER

Gay Riley, MS, RD, CCN is a Registered Dietitian and is a board Certified Clinical Nutritionist with the International and American Association of Clinical Nutritionists. She is not a physician, psychologist or other licensed health care provider ("medical health provider") and does not diagnose, prevent, treat, or cure disease.

Netnutritionist and Gay Riley are not affiliated with any medical health provider. Netnutritionist and Gay Riley offer nutrition counseling from a functional medicine perspective which emphasizes lifestyle history, biochemical individuality and the utilization of nutrition to promote physiological and biochemical balance and organ reserve, while integrating body, mind, and spirit. This approach may differ from nutrition counseling by conventional medical health providers and may not reflect views held by the Academy of Nutrition and Dietetics or the American Medical Association.

Any information, advice or interpretation of symptoms or laboratory results provided by Netnutritionist and Gay Riley is not medical advice nor is it intended to replace the medical advice or services of your medical health provider. If you have any medical or mental condition or are taking any prescribed medication, please consult your treating medical health care provider before changing your regimen.

Results may be affected by the accuracy of the information you provide as well as information you may omit to disclose. Nutritional changes can have profound, individual effects on the human body that may not be anticipated in advance. No results can be guaranteed. Accordingly, if you choose to follow any advice or undertake any diet, exercise, nutritional or supplement program recommended by Netnutritionist and Gay Riley, all risks are assumed by you. Netnutritionist and Gay Riley disclaim liability for all consequences, loss or damage from your use, misuse or inability to use any advice, products or supplements.

Dietary supplements, some functional testing and some forms of nutritional counseling will not be reimbursed by third party payor including private health insurance and Medicare.

I am personally responsible for payment for Gay Riley, MS, RD, CCN functional nutrition fees which are not covered by third party payors.

I hereby state that I have read this document and that any questions have been answered to my full and complete understanding and satisfaction. I therefore request nutritional counseling and recommendations from Gay Riley, MS, RD, CCN.

By signing this disclaimer you acknowledge that you read, understand and agree **to its terms and conditions.**

_____ _____

Date Signature, individually

_____ _____

Date Signature, on behalf of

_____

My_____

Submit this form