Debra F. Latimer Nutrition and Diabetes Associates, LLC

DIET HISTORY FORM

Name _____

Address _____ Appt. Date _____

_____ Age _____ DOB _____ Sex _____
City State Zip

Home # _____ Work # _____ Occupation _____

Number of adults in household _____ Number of children in household _____

Who does the grocery shopping? _____

Who does the cooking? _____

Physician's Full Name _____ Physician's # _____

Physician's Address _____
Street City State Zip

MEDICAL HISTORY

Do you have any of the following problems? (circle problems)

Obesity Diabetes Heart Disease High blood pressure High Cholesterol High Triglycerides

List all other health problems and when diagnosed. _____

_____

List any family issues or problems that impact your health or make it difficult for you to achieve your health goals. _____

_____

List all current prescriptions and dosages you are taking. _____

_____

_____

Please list all over the counter medications, vitamins, minerals, herbs, etc. including dosages or amounts you are taking. _____

_____

How long have you been at your current weight? _____ yrs. _____ mths.
(non-pregnant weight)

Highest weight in past 10 years _____ When and How long maintained? _____
(if pregnant, list highest non-pregnant weight)

Lowest weight in past 10 years _____ When and How long maintained? _____
(if pregnant, list lowest non-pregnant weight)

What do you consider your ideal weight? _____ Have you ever been at this weight? _____

When and how long maintained? _____

Briefly describe any methods of weight reduction you have used in the past or are currently using. _____

_____

What do you feel is the main problem in achieving your ideal weight? (circle)

Boredom Late Night Snacking Snacking All Day Skipping Meals Binging Lack Of Exercise

Other _____

Have you ever followed a special diet in the past? _____ Describe _____

Who prescribed it? _____ How long followed? _____

Appetite: (circle one) Good Fair Poor

List food allergies: _____ Food dislikes: _____

FOOD FREQUENCE AND PREFERENCE LIST

Do you drink milk? _____ How many times per day? _____ or week _____

What kind? Whole _____ 2% _____ Skim _____ ½% _____

With what meal or snacks do you normally consume milk? _____

If you do not drink milk currently, would you be agreeable to try some on a daily basis? _____ Yes _____ No

If no, state reason _____

What kind of cheeses do you like? _____

How frequently do you eat them? _____ How do you eat them? (circle) with meals use in cooking as snacks

Do you eat yogurt? _____ Plain or with fruit? _____ How frequently? _____

Do you eat ice cream? _____ Frozen yogurt? _____ Ice milk? _____ How frequently? _____

Do you drink fruit juices? _____ What kinds? _____ How frequently? _____

Do you eat fresh or canned fruit? _____ What kinds? _____ How frequently? _____

HOW OFTEN DO YOU EAT THE FOLLOWING FOODS?

Vegetables _____ How prepared? _____

Soups _____ Sweet potatoes _____ Potatoes-Baked _____ Mashed _____ Fried _____

Other _____

Eggs _____ How prepared? _____

Liver _____ How prepared? _____

Lamb _____ How prepared? _____

Pork _____ How prepared? _____ Pork products such as bacon, sausage, ham _____

Chicken/Turkey _____ How prepared? _____

Fish _____ How prepared? _____ Beef _____ How prepared? _____

Peanut butter _____ Dried peas or beans _____

White Bread/Rolls _____ Wheat Bread/Rolls _____ Tortillas _____ Biscuits _____

Noodles _____ Rice _____ Cereals _____ What kinds? _____

Coffee _____ Tea _____ Regular Sodas _____ Diet Sodas _____ Alcoholic Bev _____

Punches, Lemonade, Kool-Aid _____ Regular or Sugar Free _____

How much water do you drink per day? _____

HOW FREQUENTLY DO YOU CONSUME THE FOLLOWING?

Candy _____ Pies _____ Cookies _____ Cake _____ Sweet Roll _____ Danish _____

Muffins _____ Sugar _____ Artificial Sweeteners _____ What Type _____

Cooking or Salad Oils _____ Butter or Margarine _____ Gravies _____

Cream _____ Salad Dressing _____ Regular _____ Low Calorie _____

Mayonnaise _____ Regular _____ Light _____

Favorite Foods (List those foods you either eat frequently or would like to at frequently) _____

_____

Do you eat snacks? _____ How frequently? _____ What time of day? _____

List your snack foods _____

How many meals are eaten at home daily? _____ How often do you eat meals out each week? _____

Circle types of restaurants: Fast Foods Cafeteria Select Restaurant Menu

How often do you do the following for lunch (weekly)? Eat at Home _____

Bring lunch from home _____ Eat fast food _____ Cafeteria Food _____

Sit Down, Menu Select Restaurant _____

Do you entertain clients for lunch or dinner? _____ How frequently? _____

What type of restaurant do you usually choose? _____

Do you have a regular exercise regime? _____ What type of exercise and how often? _____

What exercise program could you follow on a regular basis? _____

Do you have any exercise restrictions? _____

Please select a typical days food intake. Indicate the amounts of foods and beverages consumed and the time you eat them. Specify how the food is prepared.

	Food:	How prepared:	Amount:
Time that you normally eat Breakfast			
Time that you normally eat Lunch			

Time that you normally
eat Dinner

Time that you normally
Snack

**********COMPLETE ONLY IF PREGNANT**********

Weight at start of pregnancy _____ Due Date _____

Exercise restrictions _____

Special considerations _____

Weight gain to date _____

**********DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE ONLY**********

Height _____ Weight _____

IBW:_____ Patient's Weight Goal: _____ BEE:_____ BMI:_____

Calories needed to maintain current weight: _____

Calories needed to lose weight: _____

Follow up is scheduled for _____

Diagnosis _____

Debra F. latimer, R.D., L.D., C.D.E.

LAST NAME	FIRST	INITIAL	ADDRESS	CITY	STATE	ZIP
					TEXAS	

DATE OF BIRTH	MALE FEMALE	CIRCLE MARITAL STATUS	S M D W O	SOCIAL SECURITY NUMBER

DRIVER'S LICENSE	PRIMARY PHONE NUMBER	CELL PHONE NUMBER	E-MAIL ADDRESS

EMPLOYER	WORK ADDRESS	WORK PHONE NUMBER	REFERRING DOCTOR

(1) PRIMARY INSURANCE	INSURANCE ADDRESS	INSURANCE PHONE NUMBER	SUBSCRIBER NAME	DOB

SUBSCRIBER NUMBER	GROUP NUMBER	*OFFICE USE:*	*COPAY AND BENEFITS*

(2) SECONDARY INSURANCE	INSURANCE ADDRESS	INSURANCE PHONE NUMBER	SUBSCRIBER NAME	DOB

SUBSCRIBER NUMBER	GROUP NUMBER	*OFFICE USE:*	*COPAY AND BENEFITS*

PATIENT SIGNATURE ON FILE AUTHORIZATION:

[ ] I authorize the release of any information required in the processing of my claims.

[ ] I authorize my insurance benefits to be paid directly to the health care provider.

X _____ _____

Patient / Guardian Signature Date

OFFICE USE: DX: AUTHORIZATION #

DATE	CPT	UNITS	CHARGE AMT	EXP. AMT	CO-PAY / METHOD