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? ________ years ________ months __________
(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)

If you are not satisfied with your current weight, what would you like to weigh? ____________________________

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? ________
If no, state reason ______________________________

What kind of cheeses do you like? ______________________________

How frequently do you eat them? ________ Do you eat them with meals, used in cooking, have for snacks? ________ (circle).

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 ________ Do you eat nuts?________ If yes, what kind? ____________________

When do you eat them, with snacks and/or meals?____________________

Dried peas or beans (i.e. lima beans, pinto beans, etc.)? ______________________________

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? ____

To help us in providing a customized meal plan for you, please list below the foods and beverages you consumed yesterday. Indicate the amounts of foods and beverages consumed and specify how the food was prepared.

	Food:	Beverage:	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