H-E-B health & wellness
NUTRITION ASSESSMENT

Please complete the following. All information will remain confidential.

GENERAL INFORMATION

NAME:		DATE:
ADDRESS:		PHONE:
		E-MAIL:
DATE OF BIRTH:		MOBILE PHONE:
MARITAL STATUS:		OCCUPATION:
PHYSICIAN:		PHYSICIAN PHONE:
INSURANCE:	POLICY#:	GROUP#:

MEDICAL HISTORY

Check box if you've ever had any of the following conditions:

☐ Cardiovascular Disease ☐ Cancer_____ ☐ Sleep Apnea ☐ Thyroid Problems
☐ Stroke ☐ Kidney Disease ☐ Respiratory ☐ High Blood Pressure
☐ High Cholesterol ☐ Foot Problems ☐ Cataracts/ Glaucoma ☐ Depression
☐ Diabetes Type:_____ ☐Other: _____

PHYSICAL FINDINGS

Do you follow a special diet for the above conditions? ☐ Yes ☐ No ☐, Please list: _____

Are you currently experiencing any of these symptoms: ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation

Appetite? ☐ Excellent ☐ Good ☐ Fair ☐ Poor, If poor why?_____

Skin? ☐ Intact ☐ Bruised ☐ Open Sore ☐ Ulcers

Swallowing difficulty? ☐ Yes ☐ No If yes, why? _____

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No If yes, how many alcoholic drinks per week? _____

Did you smoke? ☐ Yes ☐ No If yes, how long? _____

ANTHROPOMETRIC MEASUREMENS

Current Ht _____in Current Wt_____lbs IBW_____ %IBW_____UBW_____ BMI _____kg/m^2

BMI Category: ¨Underweight(<18) ¨Normal (<24.9) ¨Overweight(25-29.9) ¨Obese (30-39.9) ¨Morbid Obesity (>40)

Recent weight changes? ☐ Yes ☐ No, If yes, how much? _____

Weight History/Measurements:

LABS

DATE TESTED:

Blood Pressure _____/_____ Fasting Blood Sugar _____mg/dl

Total Cholesterol_____ HDL_____ LDL_____ Triglycerides_____

Additional pertinent labs:

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_____

MEDICATIONS ¨ NO ¨ YES

Name of Medication	Dose	Time(s) taken?
Do you take any vitamins, minerals or other diet supplements?	¨No ¨Yes	If yes, what? _____

FOOD & EXERCISE HISTORY

Do you have any food allergies? ☐ Yes ☐ No If yes, what:_____

Do you have any food intolerances? ☐ Yes ☐ No If yes, what:_____

How many meals do you eat in a day? ¨ 1-2 ¨2-3 ¨3-4 ¨4+ (check one)

What meals do you typically eat? ¨Breakfast ¨AM Snack ¨Lunch ¨Mid-day Snack ¨Dinner ¨PM Snack

How many times a week do you eat out? ¨1-2 ¨2-3 ¨3-4 ¨4+ (check one)

Do you exercise now? ☐ Yes ☐ No, If yes, what do you do and how often?_____

Do you have any physical limitations?

DIET HISTORY - Please provide a list of foods that you typically eat in 1 day. Include recipes.

HOME or PREMADE	TIME & MEAL	FOOD	PORTION
Sample: Home	12:00PM Lunch	Chicken Salad	1 Cup

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