Baptist HEALTH

Center For Diabetes
Nutrition Education Assessment

Please PRINT All Information:

Name: _____ DOB: _____ Age: _____ Sex: ❑ M ❑ F

Home/Cell Phone: _____ Work Phone: _____ May we call you at work? ❑ Y ❑ N

Occupation: _____ Work Hours: _____

Email Address: _____ Preferred Language: _____

How did you hear about our program? _____

Reason for referral to Dietitian: _____

Are you currently on any special diet? ❑ Y ❑ N If yes, what type? _____

Weight History:

Height: _____ Weight: _____ Goal Weight: _____ Weight 1 Year Ago: _____

Medical History:

Are you presently being treated for any medical problems? ❑ Y ❑ N

❑ Heart problems ❑ High Blood Pressure ❑ Kidney disease ❑ Diabetes
❑ Celiac disease ❑ High cholesterol ❑ Other: _____

_____

Are you on any prescription medications? ❑ Y ❑ N
If yes, what medications? _____

_____

_____

Exercise History:

Has the doctor restricted you from doing exercise? ❑ Y ❑ N

Type (s) of exercise you do: _____

How many times do you exercise a week? _____ For how long each time? _____

How intense is your exercise? ❑ Light ❑ Moderate ❑ Strenuous