**Dietician Specialist Ilay Polat Clinic**

 **DATE:**

|  |  |
| --- | --- |
| Name Surname: | Phone number1.2. |
| Date of birth: | [Height](http://tureng.com/tr/turkce-ingilizce/height):  | W[eight](http://tureng.com/tr/turkce-ingilizce/weight) : | Home Number:1.2. |
| Occupation: | E mail: 1.2. |
| Address: | How did you learn about us;a.İnternetb.Someone ; c.Social mediad.Diğer: |

|  |  |
| --- | --- |
| Do you have children? | C-sectionο Vaginal οYour Birth History: |
| Are you pregnant? |  |
| With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.) Example: Sarah, age 7, sister  |  |
| Blood Type (Please circle): A / AB / B / O / Unk |  |

**WEIGHT HISTORY:**

|  |  |
| --- | --- |
| Height | Current Weight |
| Weight 1 year ago? | Desired Body Weight |
| Have you had any recent changes in your weight that you are concerned about? | Would you like to be weighed today?  |

**DIGESTIVE HISTORY:**

Do you associate any digestive symptoms with eating certain foods?

How often do you have a bowel movement?

If you take laxatives, what type/brand and how often?

**Personal Dietary Goals or Issues:**

**Medications and Supplements**:

Please list all prescription medications, nutritional supplements, and herbs/botanicals you are currently taking

**Dietary supplements**

List supplements you are currently taking (Brand names also if possible)

**PAST MEDICAL AND SURGICAL HISTORY** Please indicate whether you or your relatives\* have been diagnosed with any of the following diseases or symptoms (specify which relative and the date of diagnosis). \*Relatives include: parents, grandparents, siblings

|  |  |  |  |
| --- | --- | --- | --- |
| **Illness/Disease/Symptom** | **Self: Age Diagnosed** | **Relative: Age Diagnosed** | **Describe/Specify** |
| Allergies (please specify type of allergy) ⁪  |  |  |  |
| Anemia |  |  |  |
| Anxiety or Panic Attacks |  |  |  |
| Arthritis (osteoarthritis or rheumatoid) ⁪ ⁪ |  |  |  |
| Asthma |  |  |  |
| Autoimmune condition (specify type) |  |  |  |
| Bronchitis |  |  |  |
| Cancer |  |  |  |
|  Chronic Fatigue Syndrome |  |  |  |
| Crohn’s Disease or Ulcerative Colitis ⁪ |  |  |  |
| Depression ⁪ |  |  |  |
| Diabetes (Specify: Type I, II, Prediabetes, Gestational Diabetes) |  |  |  |
| Dry, itchy skin, rashes, dermatitis |  |  |  |
| Eczema |  |  |  |
| Emphysema |  |  |  |
| Epilepsy, convulsions, or seizures |  |  |  |
| Eye Disease (please specify) ⁪ ⁪ ⁪ |  |  |  |
| Fibromyalgia ⁪ |  |  |  |
|  Food Allergies or Sensitivities |  |  |  |
| Fungal Infection (athlete’s food, ringworm, other) ⁪ |  |  |  |
| Gallbladder Disease/Gallstones (specify) |  |  |  |
| Gout |  |  |  |
| Heart attack/Angina |  |  |  |
|  Heartburn |  |  |  |
| Heart disease (specify) |  |  |  |
| Hepatitis |  |  |  |
| High blood fats (cholesterol, triglycerides) ⁪ |  |  |  |
| **Illness/Disease/Symptom** | **Self: Age Diagnosed** | **Relative: Age Diagnosed** | **Describe/Specify** |
| High blood pressure (hypertension) |  |  |  |
| Hypoglycemia (low blood sugar) |  |  |  |
| Intestinal Disease (specify) ⁪ |  |  |  |
| Infammatory Bowel |  |  |  |
| Disease (Crohn’s or Ulcerative Colitis) |  |  |  |
| Irritable bowel syndrome |  |  |  |
| Kidney disease/failure or Kidney stones |  |  |  |
|  Lung disease (specify) |  |  |  |
| Liver disease ⁪ |  |  |  |
| Mononucleosis |  |  |  |
| Osteoporosis |  |  |  |
| PMS |  |  |  |
| Polycystic Ovarian Syndrome |  |  |  |

Urinary Tract Infection

|  |  |  |  |
| --- | --- | --- | --- |
| Pneumonia |  |  |  |
| Prostate Problems |  |  |  |
| Psychiatric Conditions |  |  |  |
| Seizures or epilepsy |  |  |  |
| Sinusitis |  |  |  |
| Sleep apnea |  |  |  |
| Stroke |  |  |  |
| Thyroid disease (hypo- or hyperthyroid) |  |  |  |
| **Injuries** |  Age: | Describe/Specify |
| Back injury |  |  |
| Broken (specify) |  |  |
| Head injury |  |  |
| Neck injury |  |  |
| **Diagnostic Studies** |  |  |
| Barium Enema |  |  |
| Bone Scan |  |  |
| CAT Scan: Abdom., Brain, Spine (specify) |  |  |
| Chest X-ray |  |  |
| Colonoscopy or Sigmoidoscopy (specify) |  |  |
| EKG |  |  |
| Liver scan ⁪ ⁪  |  |  |
| NMR/MRI |  |  |
| Upper GI Series |  |  |
| **Operations** |  |  |
| Dental Surgery ⁪ ⁪ ⁪ ⁪  |  |  |
| Gall Bladder |  |  |
| Hernia |  |  |
| Hysterectomy |  |  |
| Tonsillectomy |  |  |

**LIFESTYLE**

**Physical Activity:** Using the table, please describe your physical activity

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activity**  | **Type/Intensity (low-moderate-high)** | **# Days per week** |

|  |
| --- |
| **Duration (minutes)** |

 |
| Stretching/Yoga  |  |  |  |
| Cardio/Aerobics (walking, jogging, biking, etc.) |  |  |  |
| Strength-training (weight lifting, pilates, some yoga) |  |  |  |
| Sports or Leisure |  |  |  |
| Other (specify/describe |  |  |  |

Does anything limit you from being physically active?

Do you smoke? Alcohol use?

**INTAKE INFORMATION:**

If you follow a special diet/nutritional program, check the following that apply:

|  |  |  |  |
| --- | --- | --- | --- |
| Low fat | High protein | Diabetic | Vegan |
| Low carb | No gluten | Vegetarian | Weith loss |
| Low sodium | No dairy | No wheat | Other |

**Which meals do you eat regularly, check all that apply:**

|  |  |  |  |
| --- | --- | --- | --- |
| Breakfast | Lunch  | Dinner  | Snacks |

***How do you handle stress? What helps you relax***?

**Check all of the factors that apply to your eating habits and current lifestyle:**

|  |  |  |  |
| --- | --- | --- | --- |
| Love to eat | Family members have different tastes  | Rely on convenience foodsο  | Eat fast food frequently |
|  Love to cook | Dislike cooking | Make poor snack choices | Confused about food/ nutrition |
| Emotional eater | Fast eater | Do not plan meals or menus | Live alone or eat alone often |
|  Late night eater | Erratic eating patterns | Time constraints | Travel frequently |
| Struggle with eating issues | Eat too much | Eat only because I have to | Negative relationship with food |
| Dislike healthy food | Don’t know how to cook | OTHER: |

**Food Diary:**

Please record what you eat and drink during one typical day (24 hour period). Please be sure to include all beverages, cream and sweetener added to beverages, and condiments added to foods.

|  |  |  |
| --- | --- | --- |
| Time woke up: |  | Bedtime: |
| Time | Food / Beverage Items  | Amount (e.g. cups, oz., tsp) | Location (Home/Away) |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |