SHEILA WOLFSON, M.Ed., C.N.S.
Nutritionist and Health Counselor

Send to sheilaw@sheilawolfson.com

Instructions: Complete this form in Word and then email it back.

HEALTH HISTORY

Name
Date_____Address
Phone (H) Phone(W)
Weight Height Age
Birth Date Occupation Marrital Status
Referred by Primary Health Care Provider
Reason for consultation

Family Health History

1. Indicate present health condition of (**or age & cause of death**):

maternal grandmother_____paternal grandmother_____
maternal grandfather_____paternal grandfather_____
mother_____ father_____
sisters_____ brothers_____

2. Who in your family has or had any of the following?**(M=mother, F=father,etc)**

alcoholism_____ allergies_____
arthritis_____ asthma_____
cancer_____diabetes_____
eating disorder_____ emphysema_____
glaucoma_____ heart disease_____
high blood pressure_____ kidney disease_____
mental illness_____ obesity_____
tuberculosis_____ other_____

Personal Health History

1. **Place an "O" next to any of the following conditions which you now have or have had in the past:**

abscesses	AIDS/ARC	alcoholism	allergies	anemia	anorexia
	arthritis	asthma	bloating	bulimia	cancer
colitis/lBS	compulsive eating	depression	dermatitis	diabetes	diverticulitis
emphysema	fatigue	fibromyalgia	gas	gastritis	headaches
heartburn	heart disease	hepatitis	hernia	hypertension	hypoglycemia
insomnia	jaundice	kidney disease	mental illness	mononucleosis	obesity
pain	pneumonia	rheumatic fever	sexually transmitted disease	smallpox	stroke

	thyroid disorder	tonsilitis	tuberculosis	ulcer	visual problems	other

2. Do you have any problems with your skin, hair or nails? _____

3. Do you have any problems with your teeth, bite or gums?_____
4. List all surgery you have had (include dental): _____
_____
5. Women, answer these questions about your menstrual cycle and reproductive history

- age at onset of menstruation_____
- how often menstruation occurs_____
- how long menstruation lasts_____
- premenstrual symptoms_____
- symptoms during menstruation_____
- frequency of napkin or tampon change on heaviest day_____
- drug/hormone therapy related to menstrual cycle_____
- age at onset of menopause_____
- how long menopause lasted (if ended)_____
- symptoms during menopause_____
- drug/hormone therapy during menopause_____
- number of pregnancies_____
- number of miscarriage_____ _____
- number of children (include ages)_____
- number of abortions _____
- drug therapy related to pregnancy (include DES)_____
- birth control methods_____
- vaginitis_____
- last pap smear_____
- last breast exam_____

6. Answer these questions about your early life, if you can:

- drugs your mother took during pregnancy_____
- foods your mother craved during pregnancy_____
- mother's alcohol consumption during pregnancy_____
- were you breastfed _____
- age at which you were weaned, if breastfed_____
- state of health as infant_____ _____
- state of health as child_____ _____
- state of health as teen _____ _____
- state of health as young adult_____

7. Mention any emotional or other traumas in your life that may have influenced your health:_____
_____

8. Indicate the amount of daily consumption of:
meals_____
water_____
alcohol_____
tobacco_____
coffee_____
tea (include iced tea)_____
soft drinks/diet soda_____
sweets_____
sugar substitutes_____
9.Indicate average number per day of:
hours of sleep_____
bowel movements_____
urination _____
10. Answer these questions about your elimination:
Do you have diarrhea?_____ _How often?_____
Are you sometimes constipated?_____ How often?_____
Is your elimination painful?_____
Do your stools vary with diet?_____
Do your stools vary with emotional state?_____
11. List all prescription drugs, over-the-counter drugs, recreational drugs, vitamins, herbs or homeopathic rem
you are currently
taking:_____
_____
What have you previously taken:_____
12. What health care providers(include alternative) are you currently
seeing_____
_____
Who have you seen in the past:_____
13. Are you satisfied with your weight?_____
Give a brief description of your weight
history:_____
_____
_____
14. What do you do for exercise?_____
15. What do you do to relax?_____ _____
16. How would you rate your energy level?_____
17. How would you rate your overall
health?_____ _____
18. What are the major stressors in your
life?_____
_____
19. What aspects of your life do you see as
nourishing?_____
_____
20. What are your long-term health

goals?_____
_____

21. Anything else you'd like to add:

NUTRITION INTAKE

Client _____ Date_____

1. Are there any foods you avoid for health reasons?

2. Do you have problems with: indigestion, belching gas, bloating?
3.. How is your appetite?

- How is your thirst?
- What are your favorite foods?
- What are your least-liked foods?
- Do you enjoy eating?
- Do you feel that your diet is deficient in any way? How_____
- Do you feel your diet is excessive in any way?

4. Who cooks your food?

- If you do, do you enjoy cooking?
- Who does the shopping in your household?
- Where do you shop?

5. What is mealtime like in your household?
breakfast : **lunch:** **dinner:**

- What were mealtimes like in your household growing up

breakfast **lunch** **dinner**

- Did you learn any food rules from your family?

6. Do feelings make you eat a certain way?_____
_____
Does eating make you feel a certain way?_____
_____
7. Describe your weight

history._____

_____

8. Describe your eating
history._____

HOW HAVE YOU FELT IN THE PAST 30 DAYS?

Sheila Wolfson, M.Ed., C.N.S.

0 Circle any of the following that apply to you.

Nausea or vomiting	Itchy ears	Mood swings
Diarrhea	Earaches. ear infections	Anxiety, fear or nervousness
Constipation	Drainage from ears	Anger or irritability
Bloating	Ringing in ears	Depression
Belching or passing gas	Hearing loss	Headaches
Heartburn or indigestion	Watery or itchy eyes	Faintness
Fatigue. sluggishness	Swollen or reddened eyelids	Dizziness
Apathy. lethargy	Bags or dark circles under eyes	Insomnia
Hyperactivity	Blurred vision	Irregular or skipped heartbeat

Restlessness	Chest congestion	Rapid or pounding heartbeat
Pain or aches in joints	Asthma, bronchitis	Chest pain
Pain or aches in muscles	Shortness of breath	Varicose veins
Back pain	Difficulty breathing	Hemorrhoids
Foot or leg cramps	Stuffy nose	Poor memory
Arthritis	Sinus problems	Confusion
Stiffness	Hay fever	Poor concentration
Limitation of movement	Sneezing attacks	Poor physical coordination
Muscle weakness or tiredness	Excessive mucus formation	Difficulty making decisions
Slow wound healing	Chronic coughing	Stuttering or stammering
Bruise easily	Gagging	Slurred speech
Nail problems	Frequent need to clear throat	Binge eating
Acne	Sore throat	Binge drinking
Hives, rashes or dry skin	Hoarseness or loss of voice	Craving certain foods
Hair thinning or loss	Canker sores	Excessive weight
Flushing or hot Hashes	Swollen tongue, gums or lips	Compulsive eating
Excessive sweating	Discolored tongue, gums, lips	Underweight
Menstrual pain	Frequent illness	Water retention
Menstrual irregularity	Frequent or urgent urination	Cold hands and feet
PMS	Genital itch or discharge	Heavy menstrual bleeding