AutoImmuneNutrition.net

Robert Stephens – Nutrition Consultant

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Hours: By appointment

Patient Paperwork – Female

Name:	Age:	Blood Type:
Email or Skype address:		
Phone Number:	What is the best way to contact you?	

Chief Complaints – what symptoms are you experiencing

Current medications – what medications and/or vitamins are you currently taking, including recreational drugs.

Drug or Vitamin Name	Strength	How many (take)	How often (frequency)	Date Started

Past Medical History – Current or Previous Medical Problems

Please describe any medical issues or concerns. Include any current issues, previous problems, or concerns.	When did it start?

Drug Allergies – drug allergies or vitamin allergies

Drug or Vitamin Name	Strength	What happened when you took this drug/ vitamin?

Dental: How many fillings and crowns do you have?

____

Food or General Allergies

Food or Allergy Description	What happened when you had this allergic reaction?

Surgical History – Any surgeries or procedures you have had

Please describe any surgeries both minor (wisdom teeth removal) or major	Date of surgery

Hospitalizations – describe any hospital stays and why

Reason for hospitalization	Start and End Date

Family Medical History – Current or Previous Medical Problems

Family Member	Alive/ Deceased	Medical Issues
Father		
Mother		
Grandfather – Father's Side		
Grandmother – Father's Side		
Grandfather – Mother's Side		
Grandmother – Mother's Side		
Siblings		

Social History – Current or Previous Medical Problems

Marital Status	☐ married ☐ divorced ☐ widowed ☐ single	
	Work History	
What is your current occupation?		
	Exercise	
Do you exercise?	☐ Yes ☐ No	
If yes, at your home or gym?	☐ Home ☐ Gym	
Do you have a trainer?	☐ Yes ☐ No	
Do you sweat when exercising?	☐ Yes ☐ No	
How often do you exercise?	Cardio per week: Weights per week:	
	Sleep	
Average # hours you sleep at night?		
Usual bedtime		
Usual wake-time		
	Stress	
Do you have stress?	☐ Yes ☐ No	
If yes, is how would you describe it?	☐ mild ☐ moderate ☐ severe	
	Alcohol	
Do you drink alcohol?	☐ Yes ☐ No	
If yes, please describe your drinking?	☐ social drinking ☐ Frequent Drinking	
	Smoking	
Do you smoke?	☐ Yes ☐ No	
If yes, how much?		

Gynecological History

How old were you when you first had your period? (Menarche)	
How often do you have your period?	Other: ☐ every 28 days ☐ every month ☐ every 20-25 days ☐ every 35-40 days
Describe the flow	☐ Normal Bleeding ☐ Light Bleeding ☐ Heavy Bleeding
Last Pap Smear	On what date did you have your last pap smear?
Abnormal Pap Smear	Have you ever had an abnormal pap? If so, please describe:
Contraception	Do you use ☐ Yes ☐ No contraception: If so, what type(s):

Obstetric History

Number of pregnancies	
Number of children	
Have you had any miscarriages or stillbirths?	
If you have had children, please describe the births. Were they were delivered vaginally or via C-Section Please note this for each child	

Body Composition/Nutrition/Diet

What was your maximum body weight?	
What is your desired weight?	
How many meals do you eat per day?	
How many snacks?	
How many times do you feel hungry a day?	
What food cravings do you have? What time?	
How many meals do you eat out per week?	
Do you travel? If so how often.	

Beverages

How many times per day do you consume the following beverages:

Water	
Coffee	
Alcohol	
Green/black tea	
Soda	
Juice	
Milk	

Meals

Do you follow a specific diet or eating plan, such as vegetarian, paleo, low fat, etc.? ________________

How many servings of vegetables do you eat in a typical meal? ________________________

Please list a typical meal for your diet. Please indicate if you frequently skip meals

List a typical breakfast	
List a typical lunch	
List a typical dinner	

Symptom Questionnaire

DERMATOLOGY

Dry or Sensitive Skin	☐ Yes	☐ No
Acne	☐ Yes	☐ No
Eczema	☐ Yes	☐ No

ENDOCRINOLOGY

Hair Changes	☐ Yes	☐ No

FEMALE REPRODUCTIVE

Abnormal Vaginal Discharge	☐ Yes	☐ No
Irregular Menses	☐ Yes	☐ No
Hot Flashes	☐ Yes	☐ No
Pelvic Pain	☐ Yes	☐ No
Dysmenorrhea (pain before period)	☐ Yes	☐ No
Dyspareunia (pain during intercourse)	☐ Yes	☐ No
Infertility	☐ Yes	☐ No
Frequent Yeast Infections	☐ Yes	☐ No
Breast Pain	☐ Yes	☐ No
Nipple Discharge	☐ Yes	☐ No

GASTROENTEROLOGY

Abdominal Pain	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

MUSCULOSKELETAL

Joint Pain	☐ Yes	☐ No
Joint Stiffness	☐ Yes	☐ No
Joint Swelling	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No
Myalgia (muscle pain)	☐ Yes	☐ No
Leg Cramps	☐ Yes	☐ No
Sciatica	☐ Yes	☐ No
Osteoporosis Treatment	☐ Yes	☐ No

NEUROLOGY

Headache	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No

PSYCHOLOGY

Anxiety	☐ Yes	☐ No
Sleep Disturbances	☐ Yes	☐ No

UROLOGY

Urinary Urgency	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No
Urinary Incontinence	☐ Yes	☐ No
Nocturia (waking 2+ at night for urination)	☐ Yes	☐ No
Previous UTIs	☐ Yes	☐ No

Any other symptoms, relevant information, or comments:

Disclaimer: I am not a licensed healthcare practitioner, and provide non-medical advice on alternative/complementary healthcare, or dietary advice based on principles of nutrition. I am a student in Holistic Nutrition acting as a consultant in health related topics. Natural health services are offered under the guidelines of CA SB-577 and are not required to be licensed by the State.

I am aware that no medical services are provided, only informative. I understand that the this consultation is not a substitute for medical advice or treatment

Signed ________________________________ Date __________________