AutoImmuneNutrition.net
Robert Stephens – Nutrition Consultant

916-877-6670

Hours: By appointment
office@nutrition101.org

Patient Paperwork – Male

Name:	**Age:**_______	***Blood Type:*** _________

Chief Complaints – what symptoms/problems are you experiencing

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Current medications – what medications and/or vitamins are you currently taking

Medications and Supplements	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?

Name:

Drug Allergies – *drug allergies or vitamin allergies*

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

Food or General Allergies – *any food allergies (i.e. wheat) or environment allergies (i.e. pollen)*

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 you have had	Date of surgery

Hospitalizations – *describe any hospital stays and why*

Reason for hospitalization	Start and End Date

Dental: How many fillings and crowns do you have?

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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		

Name:

Social History

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 _____	Weight Training 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?		

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?			
Do you have food cravings?			
How many times do you feel hungry a day?			
How many meals do you eat out per week?			
Do you travel? If so how often.	**Minimally**	**Moderately**	**Frequently**
Do you have digestive problems?			
Have you lived in an area where you were exposed to toxic chemicals or pollutants?			

Name:

Beverages

Please list your consumption per day or per week of the following beverages:

Water	
Coffee	
Alcohol	
Green/black tea	
Soda	
Juice	
Milk	

Meals

Please list a typical meal for your diet. Please indicate if you skip any meals or snacks regularly.

List a typical breakfast	
List a typical lunch	
List a typical dinner	
List some typical snacks	

Name:

CONSTITUTIONAL

Weight Loss O Yes O No

Weight Gain O Yes O No

Fatigue O Yes O No

CARDIOLOGY

Hypertension O Yes O No

DERMATOLOGY

Dry or Sensitive Skin O Yes O No

Acne O Yes O No

Eczema O Yes O No

ENDOCRINOLOGY

Hair Changes O Yes O No

GASTROENTEROLOGY

Abdominal Pain O Yes O No

Nausea O Yes O No

Heartburn O Yes O No

Diarrhea O Yes O No

Constipation O Yes O No

MALE REPRODUCTIVE

Difficulty with Erection O Yes O No

Diminished Sexual Drive O Yes O No

Penile Discharge O Yes O No

STDs O Yes O No

Dysuria (difficult or painful urination) O Yes O No

Name:

MUSCULOSKELETAL

Joint Pain	O Yes O No
Joint Stiffness	O Yes O No
Joint Swelling	O Yes O No
Back Pain	O Yes O No
Myalgia (Muscle Pain)	O Yes O No
Leg Cramps	O Yes O No
Sciatica	O Yes O No
Osteoporosis Treatment	O Yes O No

NEUROLOGY

Dizziness	O Yes O No
Headache	O Yes O No
Memory Loss	O Yes O No

PSYCHOLOGY

Anxiety	O Yes O No
Sleep Disturbances	O Yes O No

UROLOGY

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

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 ____________________