Geckle Diabetes and Nutrition Center
6535 N. Charles St., Suite 405
Baltimore, MD 21204
P: 443-849-2036 F: 443-849-8999

MEDICAL NUTRITION ASSESSMENT

PERSONAL INFORMATION / NAME: _____ **DOB :** _____ **DATE:** _____

Living status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Living with a partner

What medical condition are you here for? _____When were you first told about this condition? _____

Have you had nutrition education about this condition in the past? ❑ Yes ❑ No If yes, what year? _____

Do you have any cultural or spiritual practices of which you would like to make us aware that would impact the treatment/education plan we would provide to you? ❑ Yes ❑ No

If yes, please explain: _____

GENERAL HEALTH HISTORY

Please tell us the date of your last: Complete physical exam by your primary care doctor ___/___/___

Specialists (_____) ___/___/___ Specialists (_____) ___/___/___

Height ___' _____" Weight (lb) _____ Usual Body Weight (lb) _____

Hospitalizations/surgeries in last five years (date/reason): _____

_____

Are you pregnant? ❑ Yes ❑ No Are you considering pregnancy? ❑ Yes ❑ No

_____

Please check all that apply and explain.

❑ Eye or vision problems _____ ❑ Dental or mouth problems _____

❑ Sleep apnea ❑ Problems with sleeping _____

❑ Changes in appetite/weight _____

❑ Frequent (circle) nausea, vomiting, constipation, or diarrhea _____

❑ High blood pressure ❑ Stroke ❑ Heart disease ❑ High cholesterol/lipids/blood fats

❑ Foot problems _____ ❑ Numbness/pain/tingling in feet _____

❑ Circulation problems _____ ❑ Open sores on skin _____

❑ Thyroid disease _____ ❑ Kidney/bladder problems _____ ❑ Liver problems _____

❑ Feelings of tiredness/weakness ❑ Depression ❑ Problems with sexual function _____

Other problems _____

Do you smoke? ❑ Yes ❑ No If yes, how much per day? _____ would you like information on quitting? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No If yes, how much per day? _____

Do you take street drugs? ❑ Yes ❑ No If yes, please explain _____

During the past month:

1. Have you often been bothered by feeling down, depressed, or hopeless? ❑ Yes ❑ No
2. Have you been bothered by little interest or pleasure in doing things? ❑ Yes ❑ No
3. Are you involved in therapy with a counselor or psychologist? ❑ Yes ❑ No

Provider Reviewing this form with Patient: _____

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NUTRITION/DAILY ROUTINE

What food planning methods have you followed in the past? (check all that apply)
❑ Calorie counting ❑ Exchange lists ❑ Food pyramid/healthy choices ❑ Low carbohydrate
❑ Carbohydrate counting ❑ Fat gram counting ❑ No added sugar ❑ No method
❑ Plate method/portion control ❑ Other _____

What method of meal planning (if any) are you currently using? _____

How often do you follow a meal plan? ❑ 0 ❑ 1-25% ❑ 26-50% ❑51-75% ❑>75%

Please fill in/circle the times of your meals and snacks, along with an example of the type and amount of food you might eat in one day. Example: Time: 3:00-4:00 PM Typical Meals/Snacks: small bag potato chips, one bottle sweet iced tea

My Usual Routine	Time	Typical Meals/Snacks for One Day
I get up most days at	AM PM	
Breakfast	AM PM	
Morning snack	AM PM	
Lunch	AM PM	
Afternoon snack	AM PM	
Evening meal	AM PM	
Bedtime snack	AM PM	
I go to bed most days at	AM PM	

Food Preferences ❑ Vegetarian _____ ❑ Ethnic _____ ❑ Other _____

Food Allergies/Intolerances ❑ Yes ❑ No If yes, please list: _____

What specific eating concerns do you have? ❑ Heartburn ❑ Nausea ❑ Vomiting ❑ Constipation ❑ Diarrhea
❑ Loss of appetite ❑ Weight loss (losing weight without trying) ❑ Weight gain ❑ Other _____

ACTIVITY/EXERCISE

Has your doctor told you to limit your exercise in any way? ❑ Yes ❑ No If yes, explain _____

What kind of exercise do you do? ❑ Walking ❑ Biking ❑ Swimming ❑ Aerobic machine _____
❑ Sports _____ ❑ Active job ❑ Other _____

How many times per week do you exercise? ❑ 0 ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ >6

How many minutes do you exercise each time? ❑ 0 ❑ 1-15 ❑ 15-30 ❑ 30-45 ❑ 45-60 ❑ >60

What time of day do you exercise? _____

LIFESTYLE AND BEHAVIORAL CONCERNS THAT MIGHT AFFECT MY ABILITY TO TAKE CARE OF MYSELF

Check all that apply.
❑ Financial issues ❑ Language barriers ❑ Coping issues ❑ Depression
❑ Insurance issues ❑ Mobility issues ❑ Family life/home issues
❑ Transportation issues ❑ Job issues/work schedule ❑ Too busy to manage my health

What do you feel are your most important concerns in managing your health? _____

What would you like to learn during your visits? _____

PAIN If you are in any kind of pain TODAY, please rate your pain on a scale of 1 (low) to 10 (high) and provide details.
Pain level _____ Details _____

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MEDICATIONS: If you've NOT been a patient at GBMC since October 1, 2016, please list all current medications.

Medication allergies and reactions (please list): _____

CURRENT MEDICATIONS (include over-the-counter and herbal medications)

MEDICATION NAME	DOSE/FREQUENCY	REASON

Educators Name	Initials	Date	

Provider Reviewing this form with Patient: _____ Page **3** of **3**