Reproductive Medicine Associates of New York, LLP

Patient Profile: Nutrition

*Please provide your legal name (i.e. full name as listed on your social security card, passport, or driver's license).

Patient Information

Last Name* ______________________ **First Name*** ______________ M.I.____

Nickname (if applicable) ______________________

Address ______________________

City ______________ State ________ Zip Code ________

Date of Birth _____/_____/________ **Age**____

Gender: ☐ Female ☐ Male

Height: ______’_______’’ **Weight :** ________

Home # (____)________________

Work # (____)________________

Cell # (____)________________

E-Mail ________________

Diet Profile

Referred by: ______________________

What is the main reason you have come to a nutritionist?

- ☐ To lose weight before pregnancy
- ☐ To gain weight before pregnancy
- ☐ For general health and well being
- ☐ I have a GI disorder
- ☐ I have PCOS
- ☐ Other: ________________

Have you tried any of the following diets? (Check all that apply)

- ☐ Atkin's
- ☐ Jenny Craig
- ☐ Nutrisystem
- ☐ South Beach
- ☐ The Zone
- ☐ Weight Watchers
- ☐ Other: ________________

Please list the names of any nutritionists you have seen in the past and reason for visit(s): ☐ Not applicable

Name:	Reason:
________________	________________
________________	________________
________________	________________

Dietary restrictions

Mark those items you cannot or choose not to eat:

☐ Chicken	☐ Cheese
☐ Fish (all types)	☐ Cottage cheese
☐ Pork	☐ Dairy (all types)
☐ Poultry (all types)	☐ Eggs
☐ Red meat	☐ Nuts
☐ Salmon	☐ Tofu
☐ Shellfish	☐ ____________
☐ Smoked Salmon	☐ ____________
☐ Tuna	☐ ____________

Dietary preferences

List foods/ cuisines you like to eat:

For office use:
EC: ☐ Yes ☐ No

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Medical Profile

Please list the name of all physicians you see regularly, and list their specialty

Name:	Specialty:
______________________	______________________
______________________	______________________
______________________	______________________

Please list all prescription medications you are currently taking:

______________ ______________
______________ ______________
______________ ______________

Please list all vitamins, minerals, and herbs you are currently taking:

______________ ______________
______________ ______________
______________ ______________

Family history (mark all that apply):

- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart disease
- ☐ Other: ______________

Months attempting pregnancy: __________months ☐ N/A

Lifestyle Profile

How many days per month do you travel? __________/mth

How many dinners per week do you eat out? __________/wk

How many hours per week do you work? __________/ wk

Who does the food shopping in your household? __________

Do you smoke? ☐ No ☐ Yes Detail amount: __________

Do you drink alcoholic beverages? ☐ No ☐ Yes __________/ wk

Do you exercise regularly? ☐ No ☐ Yes __________/ wk

Do you belong to a health club? ☐ No ☐ Yes (if yes, please indicate which one below):

- ☐ Chelsea Piers
- ☐ Equinox
- ☐ Crunch
- ☐ New York Health & Racquet Club
- ☐ Other: ______________

Have you ever been diagnosed with any of the following conditions? (Check all that apply)

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ PCOS

Are you concerned about any other medical conditions (that you currently have or is in your family)?

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Please detail, to the best of your ability, a typical weekday and weekend day diet.

24-hour diet history

	Weekday	Weekend Day
Breakfast Time:		
Snack Time:		
Lunch Time:		
Afternoon Snack Time:		
Dinner Time:		