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St. Charles, MI 48655
989-865-9971
Fax: 989-865-6216

2544 McLeod Dr. N.
Saginaw, MI 48604
989-791-1691
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General Nutritional Appraisal

Today's Date: _____/_____/_____
Patient Name: ____ Birth date: _____/_____/_____
Address: _______________________________________ City: _______________ State: _____ Zip: ______
Phone: ____ Email: __________________________________
Gender: _____Male _____ Female Height: _______ Weight: ________
Occupation____
Live with (circle all that apply) Spouse Children Parents Pets Other

Doctors: Please list all current doctors' names and cities.

___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________

Lifestyle habits:
- ☐ I smoke _____cigarettes per day
- ☐ I drink _____alcoholic beverages per week
- ☐ I drink caffeine. Type: ____________

I participate in the following exercises:
- ☐ Strength training ______ times per week
- ☐ Aerobics _____times per week
- ☐ Flexibility training ______times per week

Allergies: Please check all that apply
- ☐ Penicillin
- ☐ Morphine
- ☐ Dye
- ☐ Pollen
- ☐ Codeine
- ☐ Aspirin
- ☐ Nitrate Allergy
- ☐ Sulfa Drugs
- ☐ Food Allergies: _________________
- ☐ Other: _________________

Please describe the allergic reaction you experienced and when it occurred.

____
____

Current Prescription Medications:

Medication Name	Strength	Date Started	How often per day

Current Nutritional Supplements: **(Please bring any nutritional supplements you take to your consultation)**

Name	How Often

Over-the-counter (OTC) issues: Please check all products that you used occasionally or regularly.

_____ pain reliever
_____ sleep aids
_____ antidiarrheals
_____ Laxatives / stool softener
_____ Diet aids / weight loss products
_____ antacids
_____ others: ________________________________

Medical Conditions / Diseases: Please check all that apply to you or an immediate family member.

Self	Family		Self	Family	
☐	☐	Allergies	☐	☐	Heart Disease
☐	☐	Alzheimer's	☐	☐	High Cholesterol or Lipids
☐	☐	Arthritis or Joint Problems	☐	☐	High Blood Pressure
☐	☐	Asthma	☐	☐	Eye Disease
☐	☐	Cancer: ___________________	☐	☐	Migraines/headaches
☐	☐	Clotting Problems	☐	☐	Osteoporosis
☐	☐	Depression	☐	☐	Thyroid Disease
☐	☐	Diabetes	☐	☐	Ulcer
☐	☐	Eczema	☐	☐	Emphysema/COPD
☐	☐	Fibrocystic breast	☐	☐	Fibromyalgia
☐	☐	Ulcers	☐	☐	GERD
☐	☐	Anxiety Disorder	☐	☐	Seizure Disorder
☐	☐	Other: ____________________	☐	☐	Other: _____________________
☐	☐	Other: ____________________	☐	☐	Other: _____________________

Diet:

Do you follow a special diet? Yes / No

If yes, what kind of diet? (Low fat, kosher, vegetarian)

____

Have you ever followed a special diet? Yes / No

Are there certain types of food that you do not want to eat? Yes / No

If yes, what are they? ____

Who prepares most of the meals in your home?

____

Who does most of the grocery shopping?

____

How many times per week do you eat out? ______

Where? ____

Have you made any food changes in your life that you feel good about? Yes / No

If yes, what kind? ____

What dietary changes would you like to make? (Please check all that apply)

- ☐ Improve eating habits
- ☐ Manage glucose levels
- ☐ Manage weight
- ☐ Improve blood pressure
- ☐ Improve activity level
- ☐ Manage fatigue
- ☐ Manage allergies
- ☐ Manage IBS
- ☐ Manage health issues
- ☐ Improve Cholesterol/Triglyceride levels
- ☐ Other: ____________________

What is your biggest health concern today?

____
____
____
____
____
____

Physical Activity readiness:

Yes	No	
☐	☐	Do you have a heart condition and your doctor recommends only supervised exercise?
☐	☐	Does exercise give you pain in the chest, neck, or left shoulder/arm area?
☐	☐	Have you developed chest pain in the last month?
☐	☐	Do you become dizzy easily?
☐	☐	Do you become breathless after mild exercise?
☐	☐	Are you taking blood pressure medication for a heart condition?
☐	☐	Do you have bone or joint problems?
☐	☐	Do you have any other condition that may exclude you from an exercise program?
☐	☐	Are you more than 30 pounds overweight?

For privacy purposes, only the parties named below may be informed of any part of the nutritional consultation:

____
____
____
____

I understand that Amy Dwyer, RPh, CN,

- ✓ is a Certified Nutritionist and Pharmacist
- ✓ will NOT diagnose or treat any medical condition
- ✓ will NOT replace the advice of my primary care physician in any way
- ✓ will help me to set up a plan of healthy diet and lifestyle, and
- ✓ will help me to decide what nutritional supplements, if any, would be safe and appropriate

Name (print): ________________________________
Signature: ________________________________
Date: ________________________________

Please fax or send this completed questionnaire to:

Healthway Compounding Pharmacy
2544 McLeod Dr., N., Ste. 2
Saginaw, MI 48604

Fax: 989-791-4603