SPRUCE STREET INTERNAL MEDICINE
2575 Spruce Street Boulder CO 80302-3806 303-449-3594

For office use only

Ht: _____ Weight: _____

Patient Information Form: Metabolism & Nutrition

Please Answer the Following Questions

Name _____ Date of Birth _____ Today's Date _____

Address _____ Phone number _____

1. What is your primary goal for being here today?
   _____
2. Do you want to loose weight? Y/ N -- If yes how much? _____
3. What is the *most* you have ever weighed? _____ At what age? ____
4. What is the *least* you have ever weighed? _____ At what age? ____
5. What is the most amount of weight you have ever lost during one attempt? _____
   How long did it take? _____ How long ago was this? _____
6. What diet plan or plans have you tried? _____
7. Do you currently or have you had problems with any of the following?
   a. Gallbladder Y/N
   b. Stomach reflux Y/N
   c. Diabetes or high blood sugar Y/N
   d. Heart disease Y/N
   e. Joint Pain Y/N
   f. Back Pain Y/N
   g. High Blood Pressure Y/N
   h. High cholesterol Y/N
   i. Depression Y/N
   j. Osteopenia or Osteoporosis Y/N
   k. Anorexia or Bulimia Y/N
   l. Thyroid Y/N
   m. Food allergies Y/N
8. Are you currently on medications for any of these problems? Y/N
   --If yes which what are they?
   _____
9. Do you like to exercise? Y/N
   --If yes, what do you do? _____ How many times per week? _____
10. Do you have any joint problems or injuries that make exercise difficult? Y/N
    --if yes, explain: _____
11. How many meals and snacks per day do you eat? _____ meals _____ snacks
12. Do you eat breakfast during the week? Y/N
    --if yes, where do you eat it? _____ What do you eat? _____
13. Do you eat lunch during the week?
    --If yes, do you bring lunch or eat out? _____
    --What is a typical lunch for you? _____
14. Typically what time of day do you eat dinner? _____
15. Do you have a favorite evening snack? Y/N
    --If yes, what is it? _____
    --What time do you eat it? _____