For office use only
Ht: ________ Weight: _______

Shoes / No Shoes

Boulder Endocrinology, PLLC *and* Boulder Nutrition & Exercise Services

Patient Information Form: Metabolism & Nutrition

Please Answer the Following Questions

Name ________________________ Date of Birth ___________ Today's Date _____________

Address _________________________________ Phone number ______________

E-mail address _________________________

1. What is your primary goal for being here today?
   ____
2. Do you want to lose 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 as an adult? _________ 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, If yes please list:_____________________
   ____
8. Are you currently on medications? Y/N
   --If yes what are they?
   ____
9. Do you take supplements? Y/N
   --If yes what are they?
   ____
10. Do you like to exercise? Y/N
    --If yes, what do you do? _____________ How many times per week? ________
11. Do you have any joint problems or injuries that make exercise difficult? Y/N
    --if yes, explain: ____
12. How many meals and snacks per day do you eat? ______ meals ______ snacks
13. Do you eat breakfast during the week? Y/N
    --if yes, where do you eat it? ____________ What do you eat? ______________
14. Do you eat lunch during the week? Y/N
    --If yes, do you bring lunch or eat out? __________
    --What is a typical lunch for you? ____________________________________
15. Typically what time of day do you eat dinner? ____________
16. Do you have a favorite evening snack? Y/N
    --If yes, what is it? ______________________________
    --What time do you eat it? ______________