Vital Care of Southwest Virginia
Nutritional Assessment

Date: _____

Demographics: please fill out completely
Name: _____ Date of Birth:___/____/_____
Address: _____
Phone: (___) _____-_____Email:_____
Height: _____ Weight: _____
BMI (Pharmacist will calculate): _____ (BMI= Wt. in Kg/Ht. in meters^2)
Has your weight changed in the last 6 months, if so, please explain. Has it been a desired change? _____
_____

Allergies:_____

Medication History: List all prescription and non-prescription medications that you are taking. (Include vitamins, herbals and supplements.)
_____
_____
_____

Medical History: Please check the following that apply to you.
___High Blood Pressure, do you follow a low sodium diet? _____
___High Cholesterol, do you follow a low cholesterol diet? _____
___Cardiovascular Disease, do you follow a special diet? _____
___Diabetes Mellitus, do you follow a diabetic diet? _____
___Osteoporosis/Osteopenia, do you take Calcium or Vitamin D?____
___Osteoarthritis/Joint Pain, do you take anti-inflammatories?

Social History: Please check the following that apply to you.
___Alcohol Use ___Glasses per day
___Smoke ___ Packs per day
___Exercise, average hours per week?_____

Do you drink coffee or soda pop in the mornings to get started? Yes No

Do you eat breakfast? Yes No

Do you eat out more than twice weekly? Yes No

Do you eat or drink meal replacements? Yes No

Do you drink 8 glasses of water or more daily? Yes No
How many meals a day do you eat? _____
How many snacks a day do you eat? _____

Use this area for any other personal health concerns or topics you would like to discuss with our pharmacist._____ _____
_____
_____
_____