Cleveland Nutrition
A Dietary Approach to Medical Care

Welcome to Cleveland Nutrition!

Thank you for giving us the opportunity to care for you and to help you achieve the best health possible through nutritional therapy.

Please take a few minutes to **completely** fill out the attached registration and health history forms and bring them to your consultation. Dr. Gutman will go over these forms with you to get a clearer understanding of your medical history. This will enable him to prepare the appropriate diet and other recommendations for your medical conditions.

The attached forms include a 3-day diet diary, so **you cannot fill this out the night before!**

Forms found after the diet diary should only be filled out if applicable to your medical history.

In addition, please bring the following items to your consultation:

- All medications and supplements that you take on a regular basis.
- The results of any blood work that you have had done in the past 6 months.
- The results of any relevant medical testing that you have had.

Please note the date, time, and location of your consultation:

Date: _____ Time: _____

□ Beachwood – 25200 Chagrin Boulevard, Suite 109

□ Fairlawn – 2660 West Market Street, Suite 250

We look forward to your visit!

Cleveland Nutrition

Important: Please recognize that we have set aside this appointment time specifically for you. If you must cancel your appointment, we request the courtesy of 48 hours advance notice. Failure to provide this notice will require us to collect a deposit of $100 before rescheduling the missed appointment. Thank you for your understanding.

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HEALTH HISTORY

Name: _____ Chart #: _____

MEDICAL HISTORY

Please check any of the following which you have or have had:

- ☐ Heart Attack/Angina
- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ Abnormal EKG
- ☐ Enlarged Heart
- ☐ Leg/Ankle Swelling
- ☐ Other Heart Disease*
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Thyroid Disease*
- ☐ Kidney Stones
- ☐ Kidney Infection
- ☐ Other Kidney Disease*
- ☐ Abnormal Mammogram
- ☐ Menstrual Problems*
- ☐ Miscarriages
- ☐ Enlarged Prostate
- ☐ Non-Cancerous Growths*
- ☐ Cysts*
- ☐ Cancer*
- ☐ Seasonal Allergies/Hay Fever
- ☐ Asthma
- ☐ Bronchitis/Emphysema
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Other Lung Disease*
- ☐ Dementia
- ☐ Stroke
- ☐ Seizures
- ☐ Numbness or Tingling*
- ☐ Dizziness
- ☐ Fainting
- ☐ Migraine Headaches
- ☐ Other Neurological Disease*
- ☐ Major Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Other Psychiatric Condition*
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other Eye Disease*
- ☐ Anemia
- ☐ Bleed or Bruise Easily
- ☐ Blood Clots
- ☐ Impaired Immune System*
- ☐ Recurrent Infections*
- ☐ HIV
- ☐ Chronic Back Pain
- ☐ Osteoarthritis
- ☐ Broken Bones
- ☐ Osteoporosis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Psoriasis
- ☐ Celiac Disease
- ☐ Other Autoimmune Disease*
- ☐ Acne
- ☐ Other Skin Disease*
- ☐ Alcoholism
- ☐ Hepatitis B, or C
- ☐ Fatty Liver
- ☐ Cirrhosis of Liver
- ☐ Other Liver Disease*
- ☐ Gallstones
- ☐ Jaundice
- ☐ Heartburn/Ulcers
- ☐ Difficulty Swallowing
- ☐ Irritable Bowel
- ☐ Spastic Colon
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Diverticulosis
- ☐ Colon Polyps
- ☐ Chronic Diarrhea
- ☐ Lactose Intolerance
- ☐ Chronic Constipation
- ☐ Blood in Stool
- ☐ Hemorrhoids
- ☐ Anal Fissures

*please elaborate:_____

_____

Other medical conditions: _____

_____

MEDICATIONS/SUPPLEMENTS

Please list ALL medications, vitamins, supplements, etc. taken regularly:

Name	Dose	Reason

Signature: _____ *Date:* _____

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HEALTH HISTORY (Page 2)

Name: _____ Chart #: _____

ALLERGIES

Please list any MEDICATION and FOOD allergies that you have:

Medication/Food	Reaction

HOSPITALIZATION AND SURGICAL HISTORY

Please list any hospitalizations or surgeries that you have had (include dates):

Do you have any implanted electronic devices such as a pacemaker or defibrillator? _____

When was your last colonoscopy? _____ (Women Only:) Last Mammogram? _____ Pap Test? _____

FAMILY HISTORY

Did either of your parents have diabetes? ☐ Yes ☐ No

	Age, if living	Health problems	If deceased, age and cause of death
Father			
Mother			
Siblings			
Children			

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No ☐ Quit_____ Packs per day _____ Years _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit_____ Number of drinks per week _____

Do you use recreational drugs? ☐ Yes ☐ No ☐ Quit_____ Type _____

Do you use tanning beds regularly? ☐ Yes ☐ No

What types of caffeine do you consume? ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Pills
How many ounces per day of each? _____ _____ _____ _____ #_____

Please rate your activity level:

☐ Sedentary (minimal or no exercise)
☐ Mild exercise (climbing stairs, walking three blocks, golf)
☐ Occasional vigorous exercise (less than 4 times per week for 30 minutes) Type _____
☐ Regular vigorous exercise (4 times per week or more for 30 minutes or more) Type _____

Do you have any medical conditions that limit the types of exercises you can do? ☐ Yes ☐ No
Explain: _____

(Women Only:) Are you pregnant? ☐ Yes ☐ No ☐ Don't know Number of prior pregnancies_____ Miscarriages_____

Signature: _____ *Date:* _____

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A Dietary Approach to Medical Care

DIET & WEIGHT HISTORY

Name: _____ Chart #: _____

1. What is your current weight? _____ Your desired weight? _____ Your height? _____

2. If overweight, when did you begin gaining excess weight? _____

3. If overweight, what do you think is the main cause of your ongoing weight problem?

_____

4. Is your spouse, fiancé, or partner overweight? _____

5. How often do you dine out or eat takeout? _____

6. What foods do you crave most? _____

7. How do you physically feel when you get hungry? _____

8. What are your worst food habits (binging, purging, night eating, stress eating, grazing, etc.)?

_____

9. What do you feel will be your obstacle(s) to successful weight loss? _____

_____

10. If applicable, describe your previous attempts at weight loss or previous diets you have followed:

Diet Type or Procedure	Year	Length Of Effort	Weight Lost	Weight Regained

11. What foods, if any, do you absolutely refuse to give up, regardless of the health consequences?

_____

12. Are there any foods that you strongly dislike or refuse to eat? (ex: lettuce, mushrooms, beans, etc.)

_____

13. Be honest! On a scale of 1-10, how motivated are you to do whatever it takes to achieve the best health you can? (This means normalizing your weight, recovering from medical conditions, getting off of medications, and protecting yourself from debilitating disease in the future.) _____

Signature: _____ *Date:* _____

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3-DAY DIET DIARY

Name: _____ Chart #: _____

Please list all foods, drinks, and snacks that you consume over a three day period.

	Day 1	**Day 2**	**Day 3**
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

Signature: _____ *Date:* _____

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A Dietary Approach to Medical Care

DIABETES HISTORY

Name: _____ Chart #: _____

1. When were you first diagnosed with diabetes? _____

2. Do you check your blood sugar regularly? ☐ Yes ☐ No How often? _____

3. If yes, what is a typical blood sugar for you? (provide a range) _____

4. If known, what is your most recent hemoglobin A1c value? _____ Last tested? _____

5. To your knowledge, do you have any of these complications from diabetes?

Complication	First Diagnosed	Noticeable to you?	Getting worse?
☐ Retina/vision damage		☐ Yes ☐ No	☐ Yes ☐ No
☐ Numbness/tingling of feet		☐ Yes ☐ No	☐ Yes ☐ No
☐ Slow digestive tract/nausea		☐ Yes ☐ No	☐ Yes ☐ No
☐ Kidney damage		☐ Yes ☐ No	☐ Yes ☐ No
☐ Prone to infections		☐ Yes ☐ No	☐ Yes ☐ No
☐ Poor circulation foot pain/amputations		☐ Yes ☐ No	☐ Yes ☐ No
☐ Heart disease		☐ Yes ☐ No	☐ Yes ☐ No
☐ Stroke or TIA (ministroke)		☐ Yes ☐ No	☐ Yes ☐ No

6. What medications do you CURRENTLY take for diabetes? When were you FIRST STARTED on these medications? How long have you been taking each medication at the CURRENT DOSAGE? How much do you think each medication is helping to SIGNIFICANTLY lower your blood sugar?

Current Medication	First Started	Current Dose Since	Helping Significantly?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Signature: _____ *Date:* _____

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A Dietary Approach to Medical Care

HEART DISEASE HISTORY

Name: _____ Chart #: _____

1. When were you first diagnosed with heart disease? _____

2. Do you ever get chest pain? ☐ Yes ☐ No When? _____

3. Have you ever had a noticeable heart attack? ☐ Yes ☐ No A silent heart attack? ☐ Yes ☐ No

4. Does your heart ever skip beats, start racing, or beat irregularly? ☐ Yes ☐ No

5. To your knowledge, do you have congestive heart failure (a weak heart)? ☐ Yes ☐ No

6. When was your most recent cholesterol test done? _____

Results: Total Cholesterol _____ LDL _____ HDL _____ Triglycerides _____

7. Have you ever had any of these tests or procedures?

Test/Procedure	Date Performed	Result
☐ Stress test (treadmill or chemical?)		☐ Passed ☐ Failed
☐ EKG		☐ Normal ☐ Abnormal
☐ ECHO (ultrasound of heart)		☐ Normal ☐ Abnormal
☐ Cardiac catheterization		☐ Normal ☐ Blockages
☐ Balloon to open blockage (angioplasty)		How many areas? _____
☐ Stent(s) placed		How many stents? _____
☐ Heart bypass surgery		How many vessels? _____
☐ Ablation procedure for arrhythmia		☐ Success ☐ Didn't help
☐ Pacemaker implanted		
☐ Cardioversion (electric shock to heart)		
☐ Defibrillator implanted		☐ Never shocked ☐ Shocked

Signature: _____ *Date:* _____

Cleveland Nutrition
A Dietary Approach to Medical Care

HEART DISEASE HISTORY (Page 2)

Name: _____ Chart #: _____

8. What heart medications do you CURRENTLY take? (Include medications for the heart, high blood pressure, water pills, cholesterol, and blood thinners.) When were you FIRST STARTED on these medications? How long have you been taking each medication at the CURRENT DOSAGE?

Current Medication - Dose/Frequency	First Started	Current Dose Since

IMPORTANT NOTE: If you are taking Coumadin or Warfarin, please discuss with your doctor whether you can be switched to a different blood thinner that does NOT get affected by eating leafy vegetables (vitamin K).

9. If you were to continue your current diet and habits, what do you believe is the likelihood that you would die from heart disease in the next 10 years?

☐ Less than 25% chance ☐ 25-50% chance ☐ 50-75% chance ☐ More than 75% chance

Signature: _____ *Date:* _____

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A Dietary Approach to Medical Care

CANCER HISTORY

Name: _____ Chart #: _____

Please fill out the following as completely as possible, for every CANCER that you have ever had.

Cancer #1:

Type/Location _____ Stage _____ First Diagnosed _____

Treatment: ☐ Untreated ☐ Surgery ☐ Chemo ☐ Radiation ☐ Other _____
Current Status: ☐ Active ☐ In Remission
Prognosis: ☐ Good ☐ Indeterminate ☐ Poor

Comments/Details: _____
_____

Cancer #2:

Type/Location _____ Stage _____ First Diagnosed _____

Treatment: ☐ Untreated ☐ Surgery ☐ Chemo ☐ Radiation ☐ Other _____
Current Status: ☐ Active ☐ In Remission
Prognosis: ☐ Good ☐ Indeterminate ☐ Poor

Comments/Details: _____
_____

Cancer #3:

Type/Location _____ Stage _____ First Diagnosed _____

Treatment: ☐ Untreated ☐ Surgery ☐ Chemo ☐ Radiation ☐ Other _____
Current Status: ☐ Active ☐ In Remission
Prognosis: ☐ Good ☐ Indeterminate ☐ Poor

Comments/Details: _____
_____

Signature: _____ *Date:* _____

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A Dietary Approach to Medical Care

AUTOIMMUNE DISEASE HISTORY

Name: _____ Chart #: _____

1. Please fill out the following table. List every AUTOIMMUNE DISEASE that you have. When were you FIRST DIAGNOSED with these diseases? What is the SEVERITY of these diseases? Are your symptoms GETTING WORSE?

Autoimmune Disease	First Diagnosed	Severity	Getting worse?
		☐ Mild ☐ Mod ☐ Severe	☐ Yes ☐ No
		☐ Mild ☐ Mod ☐ Severe	☐ Yes ☐ No
		☐ Mild ☐ Mod ☐ Severe	☐ Yes ☐ No
		☐ Mild ☐ Mod ☐ Severe	☐ Yes ☐ No
		☐ Mild ☐ Mod ☐ Severe	☐ Yes ☐ No
		☐ Mild ☐ Mod ☐ Severe	☐ Yes ☐ No

2. What medications do you CURRENTLY take for autoimmune diseases? When were you FIRST STARTED on these medications? How long have you been taking each medication at the CURRENT DOSAGE? How much do you think each medication is helping to SIGNIFICANTLY reduce your symptoms?

Current Medication	First Started	Current Dose Since	Helping Significantly?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Colitis only:

3. How many bowel movements do you typically have each day? _____

4. Have you recently seen blood in your stools? ☐ Yes ☐ No

Signature: _____ *Date:* _____