Maricopa OBGYN
Women's Health Arizona

WELCOME!

Nutrition Therapy involves not only addressing what you eat, but also how you think and feel about food which is why we do not utilize a one size fits all approach. Our dietitians work to understand YOUR needs, preferences, and goals to offer realistic and personalized solutions for your nutrition and health concerns.

INITIAL CONSULTATION:

- Detailed evaluation of your food record, medical records, and laboratory studies
- Personalized strategies for optimal results and health
- Development of your foundational action plan
- Tailored follow-up plan

REQUIRED FOR INITIAL CONSULTATION*:

1) Health History Packet & Three-Day Food Record
   - Use food log attached or My Fitness Pal app
2) All laboratory results, scope reports, and physician reports from the past 1-2 years that are relevant to your reason for visit
3) Cancellation Agreement (below)

**Our ability to fully understand your individual needs will be significantly impacted and result in a less effective outcome if you do not bring the necessary documents listed above.*

If you have any questions, please contact our office at 602-241-1671 or email moganutrition@womenshealthaz.com

CANCELLATION/LATE AGREEMENT:

All appointment cancellations must be completed 24 hours in advance. Failure to cancel within 24 hours will require FULL payment of the service.

Printed name of patient:

____

I have read and agree to the terms of this cancellation/late agreement:

____

Signature of Patient/Guardian   Date

Maricopa OBGYN
Women's Health Arizona

Name ____ Date ___________________

Occupation __________________________________ Age________ Height________ Sex ________

Marital Status: ☐Single ☐Partner ☐Married ☐Separated ☐Divorced ☐Widow(er)

Number of Children: ___________

Reasons for office visit and onset of condition: ____

____

List any current health problems for which you are being treated: ______________________________________

____

____

What types of therapies have you tried for these problem(s) or to improve your health overall:

☐Diet modification ☐Fasting ☐Vitamins/minerals ☐Herbs ☐Homeopathy ☐Chiropractic ☐Acupuncture

☐Conventional drugs ☐Other: ____

Do you experience any of these general symptoms on a regular basis?

☐Debilitating fatigue ☐Shortness of breath ☐Insomnia ☐Constipation ☐Chronic pain/inflammation

☐Depression ☐Panic attacks ☐Nausea ☐Fecal incontinence ☐Bleeding ☐Disinterest in sex ☐Headaches

☐Vomiting ☐Urinary incontinence ☐Discharge ☐Disinterest in eating ☐Dizziness ☐Diarrhea ☐Low grade fever ☐Itching/rash

Current medications (prescription and/or over the counter): ____

____

____

Laboratory procedures performed and outcome (e.g., stool analysis, blood and urine chemistries, hair analysis):

____

____

____

Maricopa OBGYN
Women's Health Arizona

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

____

____

____

Rate your recent average level of stress on a scale of 1 to 10 (1 being the lowest): ______________

Identify the major causes of stress (e.g., changes in job, residence, or finances): __________________________

____

Do you consider yourself: ☐Underweight ☐Overweight ☐Healthy weight Your weight today: ______________

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? ____________

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life-threatening activities (e.g., firefighter, police officer, etc.)? ____

____

What are your current health goals? ____

____

What are your current health challenges? ____

____

Please read the following two statements that people have made about their food situation. For each statement, please identify whether the statement was often true, sometimes true, or never true for your household in the last 12 months.

"We worried whether our food would run out before we got money to buy more." Was that often true, sometimes true, or never true for your household in the last 12 months?

☐Often True ☐Sometimes true ☐Never true

"The food we bought just didn't last, and we didn't have money to get more." Was that often true, sometimes true, or never true for your household in the last 12 months?

☐Often True ☐Sometimes true ☐Never true

Maricopa OBGYN
Women's Health Arizona

Medical History
☐Arthritis
☐Allergies/hay fever
☐Asthma
☐Alcoholism
☐Alzheimer's disease
☐Autoimmune disease
☐Blood pressure problems
☐Bronchitis
☐Cancer
☐Chronic fatigue syndrome
☐Carpal tunnel syndrome
☐Cholesterol, elevated
☐Circulatory problems
☐Colitis
☐Dental problems
☐Depression
☐Diabetes
☐Diverticular disease
☐Drug addiction
☐Eating disorder
☐Epilepsy
☐Emphysema
☐Eyes, ears, nose,throat problems
☐Environmental sensitivities
☐Fibromyalgia
☐Food intolerance
☐Gastroesophageal reflux disease
☐Genetic disorder
☐Glaucoma
☐Gout
☐Heart disease
☐Infection, chronic
☐Inflammatory bowel disease
☐Irritable bowel syndrome
☐Kidney or bladder disease
☐Learning disabilities
☐Liver or gallbladder disease (stones)
☐Mental illness
☐Mental retardation
☐Migraine headaches
☐Neurological problems (Parkinson's, paralysis)
☐Sinus problems
☐Stroke
☐Thyroid trouble
☐Obesity
☐Osteoporosis
☐Pneumonia
☐Sexually transmitted disease
☐Seasonal affective disorder
☐Skin problems
☐Tuberculosis
☐Ulcer
☐Urinary tract infection
☐Varicose veins
Other_____________________________

Medical (Men)
☐Benign prostatic hyperplasia
☐Prostate cancer
☐Decreased sex drive
☐Infertility
☐Sexually transmitted disease
Other_____________________________

Medical (Women)
☐Menstrual irregularities
☐Endometriosis
☐Infertility
☐Fibrocystic breasts
☐Fibroids/ovarian cysts
☐Premenstrual syndrome (PMS)
☐Breast cancer
☐Pelvic inflammatory disease
☐Vaginal infections
☐Decreased sex drive
☐Sexually transmitted disease
Other_____________________________
Date of last GYN exam______________
Mammogram + —
PAP + —
Form of birth control________________
# of children______________________
# of pregnancies___________________
C-section______________________
Age of first period__________________
Date of last menstrual cycle__________
Length of cycle________________ days
Interval of time between cycles
_____________________________ days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)

☐Surgical menopause
☐Menopause

Family Health History
(Parents and Siblings)
☐Arthritis
☐Asthma
☐Alcoholism
☐Alzheimer's disease
☐Cancer
☐Depression
☐Diabetes
☐Drug addiction
☐Eating disorder
☐Genetic disorder
☐Glaucoma
☐Heart disease
☐Infertility
☐Learning disabilities
☐Mental illness
☐Mental retardation
☐Migraine headaches
☐Neurological disorders (Parkinson's, paralysis)
☐Obesity
☐Osteoporosis
☐Stroke
☐Suicide
Other____________________________
____

Health Habits
Tobacco:
Cigarettes: # /day_________________
Cigars: # /day____________________
Alcohol:
Wine: # glasses/d or wk_____________
Liquor: # ounces/d or wk____________
Beer: # glasses/d or wk _____________
Caffeine:
Coffee: # 6 oz cups/d________________
Tea: # 6 oz cups/d_________________
Soda w/caffeine: # cans/d____________
Other sources______________________
Water: # glasses/d _______________

Exercise
☐5-7 days/wk
☐3-4 days/wk
☐1-2 days/wkk
☐45 minutes or more duration per workout
☐30-45 minutes duration per workout
☐Less than 30 minutes
Walk: #days/wk ______________
Run, jog, other aerobic - #days/wk
____
Weight lift: #days/wk_______________
Stretch: #days/wk_________________
Other____________________________

Nutrition & Diet
☐Mixed food diet (animal and vegetable sources)
☐Vegetarian
☐Vegan
☐Salt restriction
☐Fat restriction
☐Starch/carbohydrate restriction
☐Total calorie restriction
Specific food restrictions:
☐dairy ☐wheat ☐eggs
☐soy ☐corn ☐gluten
Other ______________________

Eating Habits
☐Skip meals (which ones)__________
____
☐One meal/day
☐Two meals/day
☐Three meals/day
☐Graze (small frequent meals)
☐Generally eat on the run
☐Eat constantly whether hungry or not

Maricopa OBGYN
Women's Health Arizona

Name ______________________________ Date ______________

Rate each of the following symptoms based on how you have been feeling overall in the past 30 days

Point Scale:
0 — Never or almost never have the symptoms
1 — Occasionally have it, effect is not severe
2 — Occasionally have it, effect is severe
3 — Frequently have it, effect is not severe
4 — Frequently have it, effect is severe

Head
_________ Headaches
_________ Faintness
_________ Dizziness
_________ Insomnia
Total ______

Eyes
_________ Watery or itchy eyes
_________ Swollen, reddened or sticky eyelids
_________ Bags or dark circles under eyes
_________ Blurred or tunnel vision (does not include near- or farsightedness)
Total ______

Ears
_________ Itchy ears
_________ Earaches, ear infections
_________ Drainage from ear
_________ Ringing in ears, hearing loss
Total ______

Nose
_________ Stuffy nose
_________ Sinus problems
_________ Hay fever
_________ Sneezing attacks
_________ Excessive mucus formation
Total ______

Mouth/ Throat
_________ Chronic coughing
_________ Gagging, frequent need to clear throat
_________ Sore throat, hoarseness, loss of voice
_________ Swollen/discolored tongue/gums/lips
_________ Canker sores
Total ______

Skin
_________ Acne
_________ Hives, rashes, dry skin
_________ Hair loss
_________ Flushing, hot flashes
_________ Excessive sweating
Total ______

Heart
_________ Irregular or skipped heartbeat
_________ Rapid or pounding heartbeat
_________ Chest pain
Total ______

Lungs
_________ Chest congestion
_________ Asthma, bronchitis
_________ Shortness of breath
_________ Difficulty breathing
Total ______

Digestive Tract
_________ Nausea, vomiting
_________ Diarrhea
_________ Constipation
_________ Bloated feeling
_________ Belching, passing gas
_________ Heartburn
_________ Intestinal/stomach pain
Total ______

Joints/ Muscles
_________ Pain or aches in joints
_________ Arthritis
_________ Stiffness or limitation of movement
_________ Pain or aches in muscles
_________ Feeling of weakness or tiredness
Total ______

Weight
_________ Binge eating/drinking
_________ Craving certain foods
_________ Excessive weight
_________ Compulsive eating
_________ Water retention
_________ Underweight
Total ______

Energy/ Activity
_________ Fatigue, sluggishness
_________ Apathy, lethargy
_________ Hyperactivity
_________ Restlessness
Total ______

Mind
_________ Poor memory
_________ Confusion, poor comprehension
_________ Poor concentration
_________ Poor physical coordination
_________ Difficulty in making decisions
_________ Stuttering or stammering
_________ Slurred speech
_________ Learning disabilities
Total ______

Emotions
_________ Mood swings
_________ Anxiety, fear, nervousness
_________ Anger, irritability, aggressiveness
_________ Depression
Total ______

Other
_________ Frequent illness
_________ Frequent or urgent urination
_________ Genital itch or discharge
Total ______

Grand Total ________

Maricopa OBGYN
Women's Health Arizona

Name____Date________________________

Day 1
Wake Up Time
Morning Meal Time
Morning Snack Time
Midday Meal Time
Afternoon Snack Time
Evening Meal Time
Evening Snack Time
Water/Drinks (not listed with meals above)
Activity/Exercise (detail type and duration)
Relaxation/Sleep (detail type and duration)

Please complete your "Diet & Exercise Log" for 3 days

1. Make note of the time you wake up.
2. List and describe in detail all foods and drinks, including the amount of each. Be sure to list everything, including condiments used (e.g., mayonnaise, mustard, relish). Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc.
3. Note the time of each meal or snack.
4. Include any strong feelings, symptoms or changes in energy that may arise either between meals or relative to foods you are consuming (e.g. happiness, sadness, anger, indigestion, fatigue).
5. Keep track of how much water you drink and list the amount in ounces (or ml or l) in the section provided. Also note the type and amount of any other drinks you consume.
6. Write down any activity or exercise you do, listing the kind of exercise you did and for how long you did it.
7. Note any periods of relaxation and what kind of relaxation it was.
8. Note the time you go to sleep.

Notes:

____
____
____
____
____
____

Maricopa OBGYN
Women's Health Arizona

Day 2
Wake Up Time
Morning Meal Time
Morning Snack Time
Midday Meal Time
Afternoon Snack Time
Evening Meal Time
Evening Snack Time
Water/Drinks (not listed with meals above)
Activity/Exercise (detail type and duration)
Relaxation/Sleep (detail type and duration)

Day 3
Wake Up Time
Morning Meal Time
Morning Snack Time
Midday Meal Time
Afternoon Snack Time
Evening Meal Time
Evening Snack Time
Water/Drinks (not listed with meals above)
Activity/Exercise (detail type and duration)
Relaxation/Sleep (detail type and duration)

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