Diabetes & Nutrition Counseling
HEALTH ASSESSMENT

Date ____________ Name _______________________________________ Date of Birth _____________

Circle learning problems (visual, hearing, anger, reading, language, learning disabilities, denial)

MEDICAL HISTORY

Circle **yes or no** if you have:

High Blood Pressure	Yes	No	Polycystic Ovary Syndrome	Yes	No
Heart Disease	Yes	No	Prediabetes (Impaired glucose)	Yes	No
Chest Pain	Yes	No	Hypoglycemia	Yes	No
Kidney Disease	Yes	No	Metabolic Syndrome/Syndrome X	Yes	No
Eye Disease	Yes	No	Breathing Problems	Yes	No
High Cholesterol	Yes	No	Poor sleep/snoring/wake up tired?	Yes	No
Diarrhea	Yes	No	Constipation	Yes	No
Depression/Anxiety	Yes	No			

List other health conditions/procedures____

HEALTH HABIT HISTORY Circle **yes** or **no** if you:

Smoke	Yes	No	Use recreational drugs	Yes	No
Drink alcohol	Yes	No			

Explanation ____

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Print Name

___________________________________ ______________ _____________

Signature Educator Initials