TMH PHYSICIAN PARTNERS

The Outpatient Nutrition Programs of the
TMH Physician Partners – Metabolic Health Center
2633 Centennial Blvd, Suite 100
Tallahassee, Fl 32308
850 431-5404/FAX 850 431-4838

Dear Patient and Family:

Welcome to the Nutrition Programs of the Metabolic Health Center! Our staff of registered dietitians are here to provide you with nutrition counseling to help you successfully manage your condition.

Please note that your insurance company will be billed for these services unless other arrangements were made before your scheduled appointment. You will be responsible for any non-covered benefits, unmet deductible, co-payment, or co-insurance. We have found that most insurance companies do not cover nutritional counseling. NOTE: Should you have any questions regarding insurance coverage, please contact your insurance company first and then follow up with us if you have more questions. If you want to check coverage with your insurance company, please let them know that we are a hospital outpatient facility.

Once we receive a completed referral from your doctor, we will call to schedule your appointment. The appropriate paperwork should be filled out in full and brought with you the day of your first appointment together with your photo identification. If you are unable to complete the paperwork before your scheduled appointment, please call us to reschedule.

Kindly give us at least 24 hour notice if you are unable to keep this appointment. This will allow us to give better care to all of our patients because we consistently have patients waiting for appointments who could then be seen at an earlier time. (You also may be asked to reschedule your appointment if you arrive 10 minutes late.)

Thank you for your consideration and cooperation. We look forward to seeing you.

Respectfully,

TMH Physician Partners - Metabolic Health Center Administration

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OUTPATIENT NUTRITION QUESTIONNAIRE

Name: _____ DOB: ____/____/____

Age: _____ Race: _____ S.S.# _____
Level of Education Completed: □ Grade school □ High School □ College □ Trade/Vocational

Primary Care Physician: _____ Referring Physician: _____

Home Phone #: _____ Work #: _____ Cell #:_____

Emergency contact (name): _____ phone: _____

Occupation: _____ Work hours: _____

Please check any recent major stresses:
□ recently married □ recently divorced □ death in family □ job change □ other: _____

Are you in a family situation where you fear for your safety? □ Yes □ No
How many people in your household, including you? _____

MEDICAL HISTORY
Please check YES or NO to any of the following medical conditions that apply to you:

High Blood Pressure	□ No	□ Yes	Heart Disease	□ No	□ Yes
Stroke	□ No	□ Yes	Kidney disease	□ No	□ Yes
Constipation	□ No	□ Yes	Indigestion	□ No	□ Yes
Diarrhea	□ No	□ Yes	Chronic pain	□ No	□ Yes
Diabetes	□ No	□ Yes	Pre-diabetes	□ No	□ Yes

Please list any other health problems that you have:_____
Have you been hospitalized in the past year? □ No □ Yes If yes, for what? _____

Do you smoke or chew tobacco? □ No □ Yes, how often? _____ How much? _____
Do you have any religious, cultural or personal health beliefs that you would like us to consider as we develop your therapy or meal plan? _____

Do you drink alcohol? □ No □ Yes, how often? _____ How much? _____

PHYSICAL ACTIVITY HISTORY:
What type of exercise do you do regularly and how much time each week do you spend doing them?
(ex. Walking, swimming, biking, etc.)

Activity	Days per week	Minutes per activity
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you perform other physical activities of daily living, such as housework, gardening, or climbing stairs?
□ No □ Yes, type and amount:_____

Have you been advised to exercise by your physician? □ No □ Yes Restrictions? _____

Name_____ DOB_____

NUTRITION HISTORY

Have you ever seen a Dietitian?_____
Are you following any type of meal plan/diet, such as calorie or carbohydrate counting, low-carbohydrate, low-cholesterol, low- sodium or low fat? □ No □ Yes, explain: _____

Which diets have you tried in the past? _____

Please describe below what you typically eat in a 24 –hour period:
Breakfast – Time: _____ AM/PM Food/drink: _____
Lunch – Time: _____ AM/PM Food/drink: _____
Dinner – Time: _____ AM/PM Food/drink: _____
Snacks – Time: _____ AM/PM Food/drink: _____
Who does the shopping/cooking? _____
Please check approximately how often you eat the following foods:

High fat meats like sausage, bacon, hot dogs and ribs:
❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

Whole milk, cream, cheese, ice cream:
❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

Fish:
❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

How is your fish usually cooked?_____How is your meat usually cooked?_____

Sweets like candy, cakes, cookies, pies:

❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

Vegetables like greens, broccoli, lettuce, cabbage, green beans, and carrots:

❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

Whole grains like oatmeal, cheerios, whole wheat bread or brown rice:

❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

Do you drink sugar sweetened drinks like soda, Gatorade, Kool-Ade or sweet tea?

❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

Please list any food allergies: _____

What information would you like from the dietitian?

□ Meal planning □ How to lower cholesterol □ Grocery shopping □ Weight management
□ Record keeping □ Eating out □ Exercise □ Food label reading
□ Other: _____

Date of Assessment: _____
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For Office Use Only
ICD-10- Code: _____

PATIENT MEDICATION and SUPPLEMENT LIST

Name:_____ **DOB:**_____ **Physician:**_____
Pharmacy:_____
Medication Allergies:_____

Medication name	Dose	Taken by	Frequency (times per day)
		□ mouth □ injection □ inhaled □ _____	
		□ mouth □ injection □ inhaled □ _____	
		□ mouth □ injection □ inhaled □ _____	
		□ mouth □ injection □ inhaled □ _____	
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Reviewer Signature/Date/Time

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

** Notice to Patient** Keep an updated medication list with you at all times in case of emergency situations. Update the information when medications are changed or discontinued. If you have been seen for a consult, give a copy of your medication list to your Primary Care Physician

rev. 5/14;03/16; 5/17