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 PP Metabolic Health Center Administration

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

____________________________________ ____________________________________ ___________
____________________________________ ____________________________________ ___________
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____________________________________ ____________________________________ ___________

** 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

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