REGISTRATION FORM
Center for Nutrition and Diabetes Care

DATE:	TIME:	LOCATION:

Patient Name:	Date of Birth:

Street Address:	City	State	Zip:

Home Phone:	Alternate/Cell Phone:	Do you consent to receive email from Virtua? ☐ Yes ☐ No	Email Address:

Social Security #:	Sex: ☐ Male ☐ Female	Marital Status: S M D W	Religion:	Race/Ethnicity:

Diabetic: ☐ Yes ☐ No	Complaint/Diagnosis:	If pregnant - date of last menstrual period:

Family Physician:	Address:	Phone:
Referring Physician :	Address:	Phone:

Employer Name:	Employed: Full Time: ☐ Part Time: ☐	Occupation:
Employer Street Address:	City, State, Zip:	Work Phone:

Emergency Contact Name:	Relationship to patient	Phone: Alternate Phone:

Emergency Contact Street Address:	City, State, Zip:

Primary Insurance Name:	ID #:	Secondary Insurance Name:	ID #:
Group #	Referral #	Group #:	Referral #:
(Primary Ins.)Subscriber:	Relationship to Patient:	(Secondary) Subscriber:	Relationship to Patient:
(Primary Ins.) Subscriber SS #	Date of Birth :	(Secondary) Subscriber SS #	Date of Birth:
(Primary Ins.) Subscriber Employer Name:	Full Time: ☐ Part Time: ☐	(Secondary) Subscriber Employer Name:	Full Time: ☐ Part Time: ☐
(Primary Ins.) Subscriber Employer Address & Phone #:		(Secondary) Subscriber Employer Address & Phone #:	

If under 18 years old- Guarantor Name:	Address: City, State , Zip

Phone:	Guarantor Social Security #:	Guarantor Date of Birth:	Relationship to Patient:

Name: ____ ☐ Male ☐ Female

Date of Birth: ____________________ Age: _______________

Referring Physician: ____

NUTRITION HISTORY

Primary Physician: ____

PATIENT PROFILE: ***Patient to complete, comment as appropriate***

NUTRITION HISTORY:

What is the reason for your appointment today? ____

____

Bariatric Surgery Type? (if applicable) ____

Tube Feeding? (if applicable) Formula: ____________________Rate/hour: ________Total Hours running: _____

MEDICAL HISTORY:

Check if you've ever had any of the following conditions:

	Stroke		Foot Problems		Depression/Mental Illness
	Heart Attack/MI		Neuropathy		Retinopathy
	Heart Bypass/Stents		Amputation		Cataracts
	Pacer/AICD		Sleep Apnea		Glaucoma
	High Cholesterol		Breathing Problems		Cancer
	High Blood Pressure		Arthritis		Type? _____________
	Circulation Problems		Gestational Diabetes		Celiac Disease
	Thyroid problems		PCOS		Bowel Surgery
	Kidney Disease		Diabetes		Weight Loss Surgery

Other: ____

GI SYMPTOMS:

	Abdominal discomfort		Dysphagia		Nausea
	Constipation		Flatulence		Reflux
	Diarrhea		Heartburn		Vomiting

Other:____

MEDICATIONS:

Please write all medications here or provide a separate list.

Name	Dose	Name	Dose

Food allergies or intolerances? ____

____

VITAMINS/HERBAL SUPPLEMENTS:

Name	Dose	Name	Dose

WEIGHT HISTORY:

Height ___________ **Current weight** __________ **Usual weight** _________

Recent weight loss or gain? _______________ **Goal weight** _____________

Have you ever used laxatives, diet pills or vomited in order to lose wt? ☐ **NO** ☐ **YES**

If Yes, which of these did you use? ______________________________________

Any previous diets? ☐ **NO** ☐ **YES** **Type/Approx. dates?**

____

____

____

Who is responsible for food shopping? _________________________

Who is responsible for the cooking? _____________________________

How often do you dine out? _________________________________

ACTIVITY:

Do you work outside the home? ☐ **NO** ☐ **YES** ***Work hours:*** ____________________

Is your job?: ☐ **N/A** ☐ **Active** ☐ **Inactive**

What type of exercise do you do? ____

How much? __________ **minutes** _________**days per week**

SOCIAL HISTORY:

Do you drink alcoholic beverages ☐ **NO** ☐ **YES**

Type ______________________ **How much?**___________________ **How often?**__________________

Over the past 2 weeks, have you been bothered by any of the following problems?

1. **Little interest or pleasure in doing things** ☐ **NO** ☐ **YES**
2. **Feeling down, depressed or hopeless** ☐ **NO** ☐ **YES**

3 Day Food Diary **Name _______________________ Date of Birth_________________**

Day		Time	Food , Drinks with Amount
1	Breakfast		
	Lunch		
	Dinner		
	snacks		
2	Breakfast		
	Lunch		
	Dinner		
	snacks		
3	Breakfast		
	Lunch		
	Dinner		
	snacks		