Maternal Health Matters: Nutrition for mother and child
348 13th Street Suite 201 Brooklyn, NY 11215/ 149 Madison Avenue Suite 903 New York NY 10016
Tel.718.832.7182/Fax 866-368-6432/www.maternalhealthmatters.com

Patient Information

Patient # (to be filled in by office)	Date of Appointment:

Name	Date of Birth
Mailing Address	Email address:
Tel. (evening) Tel. (home)	Cell
Insurance Provider/Plan Name	Member ID
Co-pay	Referral needed?
Insured Name (if other than self):	Insured Date of Birth:
Referring doctor:	Doctor contact info:

Reason for coming?

Please check any conditions you have or have had.

□ Heart disease, including heart attack, congestive heart failure, stroke, or atherosclerosis
□ Type II Diabetes Mellitus
□ Cancer. List type _____
□ High cholesterol and/or high triglycerides and/or high HDL and/or low HDL
□ Allergy, intolerance or sensitivity to any food. List food(s)

□ Other. Please describe.

Has your mother, father, grandmother or grandfather ever suffered from any of the following? (Check all that apply)

□ Heart disease, including heart attack, congestive heart failure, stroke, or atherosclerosis
□ Type II Diabetes Mellitus
□ Cancer. List type _____
□ Obesity. (Defined as a BMI 30 or greater)
□ Other. Please describe.

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Please list all medications (generic or brand) and the reason you are taking it.
1.
2.
3.
4.
5.
Please list all over-the-counter medicines, vitamins & minerals or herbal supplements that you are taking and the reason you are taking it.
1.
2.
3.
4.
5.

Do you smoke? *(circle your answer)*	Yes	No
If you answered yes, how much do you smoke each day?		
Do you drink alcohol? *(circle your answer)*	Yes	No
If you answered yes, how much do you drink each day? Please list type of alcohol.		