UNIVERSITY OF MIAMI
PATTI & ALLAN HERBERT
WELLNESS CENTER

DIETARY ASSESSMENT

Department of

FITNESS & WELLNESS PROGRAMS

MEDICAL HISTORY FORM

Name (First & Last):	Date of Birth:
Email: Phone Number: C# (if applicable):	Sex assigned at birth: Gender identification:

Membership Type: ☐ Student ☐ UM Employee Member ☐ Alumni Member ☐ Non-Member

The CHAMP (basic fitness assessment) may require a physician's consent to participate.

ASSESS YOUR HEALTH BY MARKING ALL TRUE STATEMENTS:

You have experienced:

☐ chest pain at rest or with mild exertion
☐ dizziness, fainting, or blackouts with mild exertion
☐ unusual fatigue or shortness of breath during usual activities
☐ irregular heart beat or palpitations at rest or with mild exertion
☐ ankle swelling

You have had:

☐ heart attack
☐ **any** heart surgery (inc. catheter)
☐ heart murmur
☐ PVD (claudication)
☐ congenital heart disease
☐ cardiac arrhythmia
☐ diabetes (Type I or II)
☐ cardiovascular disease
☐ heart failure
☐ kidney disease
☐ hypertension
☐ stroke

☐ I perform planned, structured, moderate intensity exercise **for at least** 30 minutes per session, at **least** 3 days per week, for **at least** the last 3 months.

☐ I **DO NOT** participate in planned structured exercise as described above.

Check all that apply:

☐ you smoke
☐ you take blood pressure medication
☐ you have high cholesterol or take cholesterol medication
☐ your blood pressure is greater than 130/80
☐ you take medicine to control your blood sugar
☐ you are overweight
☐ you have a close blood relative who had a heart attack before age 55 (father/brother) or age 65 (mother/sister)

☐ bone/joint problem: ______________________________
☐ low back pain
☐ unusual muscle fatigue/soreness

Please list (check box if not applicable):

Current medications:	☐ not applicable
Recent surgeries:	☐ not applicable
Current injuries:	☐ not applicable
Physical limitations:	☐ not applicable

I UNDERSTAND THAT ALL APPOINTMENT CANCELLATIONS MUST OCCUR 24 BUSINESS HOURS IN ADVANCE. FAILURE TO DO SO WILL RESULT IN A $10.00 ADMINISTRATIVE FEE.________ (MUST INITIAL HERE)

WAIVER AND SIGNATURES

I answered the questions accurately and correctly. I understand that my medical history is an important factor in the development of my exercise and fitness program. Medicine is not an exact science and no guarantees can be made as to the safety of exercise activities. I understand that known, unknown, or undisclosed medical or physical conditions may result in injury. I knowingly and willingly assume all risks, and I hereby release The Department of Wellness and Recreation, The University of Miami, its agents and employees from any and all liability, damage, or loss arising of/or resulting from my participation in this program or service, especially including any negligence of the University's part.

Print Name **Participants Signature** **Date**

Witness Signature (Mandatory if under 18 years old) **Date**

For Staff Use Only:

Date received: ___________ MD consent required: Y or N Consent requested: ___________ Consent received: ___________

Appointment date: ___________ Staff assignment: ___________

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Nutrition/Dietary Assessment

Name (First & Last):
Age: **Height:** **Weight:**

I live: ☐On Campus ☐Off Campus Year In School: ____________________
(freshman, sophomore, junior, senior, grad student)

Major: ____________________________________
Referred by: ________________________________ (self, healthcare provider, etc.)

Have you seen a Nutritionist before? ☐ Yes ☐No If yes, why and when ___________________

Are you on a special diet? ____
(Gluten-free, vegan, vegetarian, low FODMAP, low cholesterol, kosher, etc.)
Food Allergies or intolerance: ____
What foods do you avoid: ____
Why do you want to see a Dietitian?

- ☐Healthy meal planning
- ☐Concern about weight gain in college
- ☐Healthy weight loss
- ☐Healthy weight gain
- ☐Sports nutrition
- ☐Stress over/ under eating
- ☐Dining hall over/ under eating
- ☐Hunger management
- ☐Food allergies or intolerances
- ☐Gastrointestinal disorder (IBS, Colitis)
- ☐Vegetarian/vegan
- Other: ____________________________

Do you drink alcohol? ☐Yes ☐ No
if yes, how many times a week and per sitting? _______________________________________
Do you smoke? ☐Yes ☐ No ☐ Recently quit
Do you currently exercise? ☐ Yes ☐No
How many times a week and for how long? ____

List any prescribed, over the counter, herbal or vitamin supplements you take:
____
____
____

To tailor this counseling experience to your needs, we would like to know your expectations. Please indicate the amount of structure you believe meets your needs, choose one:

☐ Tell me exactly what to eat for all my meals and snacks. I want a detailed food plan.
Example: ½ cup oatmeal, 1 cup blueberries, 1 tablespoon peanut butter, 2 hard boil eggs
☐ I want a lot of structure but freedom to select foods. I want to use the exchange system.
Example: 1 milk, 2 starches, 1 fruit, and 1 fat exchange
☐ I want some structure and freedom to select foods. I want to use a food group plan.
Example: 1 serving of dairy foods, fruits, and fat and oil group; 2 servings of grains
☐ I don't want a diet. I just want to eat better and set goal each session.

Please add any additional information you feel may be relevant to understanding your nutritional health (chronic disease, prior surgeries, etc.)
____
____
____

Complete short Food Frequency Questionnaire per day and/or per week to the best of your abilities:

Food Group	Serving Sizes	Serving per day	Serving per week	Never/ rarely
Refined Grains: white bread pasta, cereals OR Whole Grains: whole wheat bread, brown rice, quinoa, oatmeal	1 Slice bread 1 cup cereal 1/2 cup cooked rice, pasta or cereal 1/2 bagel English muffin			
Vegetables	1 cup raw leafy vegetable 1/2 cup cooked or raw vegetables 6oz vegetable juice			
Fruits	1/2 cup juice medium fruit 1/4 cup dried fruit 1/2 cup fresh, frozen, or canned fruit			
Low Fat dairy OR Whole fat dairy	8 oz. milk 1 cup yogurt 1 oz. cheese or 1 slice			
Lean meats, poultry, fish OR High fat meats, sausage, cold cuts, bacon, ribs	3 oz.			
Nuts, seeds, dry beans	1/4 cup nuts 2 tbsp. seeds 1/2 cup cooked dry beans 4oz tofu 1 cup soy milk 2 tbsp. nut butter			
Fats and oils	1 tbsp. regular dressing 2 tbsp. light dressing 1 tsp. oil 1 tbsp. mayo 1 tsp. butter			
Sweets	1.5 oz. candy (bag of M&Ms) Cookies (2 cookies Oreo size)			
Alcohol	12 oz. beer 5oz wine 1 shot spirits			

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24-Hour Dietary Recall

Name:
Date recorded:

List any nutritional supplements you take:

Total amount of money spent on food last month:

Meal Type:
1= Morning
2= Mid-Morning
3= Noon
4= Afternoon
5= Evening
6= Late evening

Serving Abbreviations:
Tablespoon = TBSP
Cup = c
Teaspoon = tsp
Pound = lb.
Ounce = oz.
Slice = sl.

Record what you eat and drink in 24 hours. Please be thorough. Try to record as close to a typical day of consumption as possible.

Food and Beverages Consumed **Describe in detail. List one food item per line.**	**Meal Type**	**Amount Eaten**
Example: Omelet		
Eggs	*1*	*2*
Mozzarella cheese	*1*	*1 sl.*
Spinach	*1*	*¼ cup*
Whole wheat Ezekiel bread	*1*	*2 sl.*
Butter	*1*	*1 TBSP*
Strawberries	*1*	*½ cup*
Blueberries	*1*	*¼ cup*