Outcomes

NUTRITIONAL SUPPLEMENTATION

PATIENT INFORMATION *(Please print clearly)*

Last Name: **First Name:**	**D.O.B.:** **Age:** **Gender:** **Height:** **Weight:**
Home Address:	Contact Phone:
City:	State: Zip:
Primary Care Physician:	Physician Phone:
Physician Address:	Physician Fax #:
Please state any past medical history and chronic conditions:	
Current medications:	
Allergies (please state reaction that occurs when exposed to the allergen):	
Vaccination history:	

SCREENING QUESTIONNAIRE

	Yes	No	Don't Know
Do you currently consume alcohol? *If yes, how many drinks per week?*	☐	☐	☐
Do you currently smoke tobacco? *If yes, how many packs per day?*	☐	☐	☐
Do you have any allergies or hypersensitivity to any food or medications? *If yes, please specify:*	☐	☐	☐
Have you ever had abnormally high storage levels of vitamins (hypervitaminosis)?	☐	☐	☐
Do you have a weakened immune system or are you currently on any medications that weaken your immune system (e.g. cortisone, prednisone, other steroids, anticancer drugs or had any radiation treatment)?	☐	☐	☐
Have you had Bariatric surgery, Malabsorption, Non-healing wounds, Acute gastroenteritis, Eczema, Irritable bowel syndrome, Clostridium/Antibiotic associated diarrhea? *If yes, please indicate:*	☐	☐	☐
Are you on a Vegan diet?	☐	☐	☐
Is your diet low on fruit and vegetable intake? *If yes, please explain:*	☐	☐	☐
Are you on any of the following? *If yes, please indicate:* • Metformin or orlistat • Albuterol, Levalbuterol, formoterol, salmeterol, vilanterol (or any beta agonists) • Prednisone, Cortisone (or any corticosteroids) • Chlorthalidone, hydrochlorothiazide, furosemide, spironolactone (or any diuretics) • Omeprazole, esomeprazole, lansoprazole (or any proton pump inhibitors) • Famotidine, Cimetidine (or any H2 blockers) • Atorvastatin, pravastatin, simvastatin (or any statins)	☐	☐	☐