***New* West Physicians Diabetes and Nutrition Center**

Gretchen Broecker, MS, RD, CDE Kathleen Peralta, RD, CDE

New Patient Pre-Diabetes / MNT Questionnaire

Patient Name:________________________________ Birth Date:___________ Today's Date:_________

Home Phone:________________________________ Work/Cell:______________________________

E-Mail:______________________________________ Occupation:_____________________________

❑ Please use my e-mail address to sign me up for the quarterly New West Physicians newsletter.
❑ Please use my e-mail address to add me to the Diabetes and Nutrition Center Event Contact List.
❑ Please use my home address to add me to the Diabetes and Nutrition Event Contact List

How tall are you?_____________________ How much do you weigh?___________________

Are you happy with your weight? ❑Yes ❑No If no, what is your goal weight? _____________

Are you on a special diet? ❑Yes ❑No If yes, what type?_______________________

How often do you exercise? ❑ Never ❑____Times per Week ❑____ Times per Month

What type of exercise do you do?___________________________/for how many minutes?_______________

Do you Smoke or Chew Tobacco? ❑Yes ❑No If yes, when did you start?________________________

How much per day?___________________________ On a scale of 1 to 10, how ready are you to quit?:

Not at all: 1 2 3 4 5 6 7 8 9 10 :Very Much

Are you exposed to second hand smoke? ❑Yes ❑No

How often do you drink alcohol?

❑ Never ❑____ Times per Week ❑____ Times per Month ❑___Times per Year

Do you have a support person? (Someone to help you in an emergency.) ❑Yes ❑No

Over the past two weeks have you felt down, depressed, and or hopeless? ❑Yes ❑No

Over the past two weeks have you felt little interest or pleasure in doing things? ❑Yes ❑No

Medications List.

Please include over-the-counter, vitamins, herbs, and supplements as well as prescriptions.

If you cannot fit all your medications on this table, please list them on a separate sheet of paper.

Medication	Dose	Times per Day	Reason
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			