



Grant Williams MD
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 (805) 564 2900 (805) 564 2988 (Fax)

Name _____ Date _____ MR# _____

New medications or supplements: _____

Has there been any new medical diagnosis or treatment, medical or surgical, that you have been give or undergone? Yes No If yes, please explain _____

STRESS/SLEEP

Which of the following best describes your current stress(es)?

- Family Financial Work related Personal Illness Travel
- Sleep disruption Other _____

Are these stresses keeping you from following your nutrition and lifestyle program? Yes No

NUTRITION

What is your current lifestyle plan? _____

Restrictions? Gluten Dairy Eggs Soy Other _____

Are you following the balanced nutrition plan as prescribed? Yes No Mostly

If no or mostly, which best describes what you are doing?

- Skipping meals Eating too many carbohydrates for your activity level
- Not eating enough vegetables Not drinking enough water
- Not eating enough healthy fats Eating too many man-made carbohydrates
- Not eating enough protein Eating too few carbohydrates-less than 15 gm 5x/day
- Eating too many damaged fats (trans-fatty acids or hydrogenated)

STIMULANTS/SUGAR/CHEMICALS

Are you ingesting any of the following? If yes, please quantify (i.e., coffee 3/day)

- Coffee _____ Tobacco in any form _____ Tea _____ Ice Tea _____ Soda _____
- Fruit juice _____ Decaf coffee _____ Milk _____ Fruit Juice _____ Diet soda _____
- Artificial sugar _____ Desserts _____ Alcohol _____



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EXERCISE

Are you getting enough exercise? Yes No

What are you doing? _____

If not, why not? _____

HORMONE BALANCING (if applicable)

- Change in hair/skin Hot flashes/night sweats Decreased libido
- Brain fog/decreased mental clarity Other _____

OTHER

Is there anything else you want to discuss? Yes No

If yes, please explain _____

Would you like us to schedule or perform any of the following for you?

- Nutrition review with our licensed dietitian Bone density study Mammogram
- Review of vitamins and supplements with our licensed dietitian Ultrasound of uterus
- Stress management session Pap smear Breast exam

MEN ONLY

When was your last prostate exam? Date _____

WOMEN ONLY

Are you current with mammograms? Yes No Date of last exam? _____

Are you current with your PAP smear? Yes No Date of last exam? _____

Do you do routine breast self exams? Yes No Date of last exam? _____

If not, why not? _____