BACK TO HEALTH WELLNESS CENTER

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Date: _____ Name: _____

Please list the foods you ate yesterday:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

Please describe what you usually eat for:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

If you previously filled out the below information then leave it blank.

List of Medications Currently Taking

Prescribing doctor or clinic: _____

	Medication	Dosage per tablet	# Times a day	How long on it?	Reason for Medication
1					
2					
3					
4					
6					
7					

Vitamins, Minerals, Herbs, Omega oils, etc. Currently Taking

Who prescribed or recommended these:_____

	Medication	Dosage per tablet	# Times a day	How long on it?	Reason for Medication
1					
2					
3					
4					
5					
6					
7					