DE FELIPE
Dermatology Clinic

PERSONAL DATA

NAME: AGE:

SURNAME: GENDER:

DATE OF BIRTH: EMAIL:

ADDRESS:

PHONE NUMBER:

REASON OF THE VISIT

WRITE HERE:

OTHER RELATED DATA

HOUSEHOLD MEMBERS:

DO YOU HAVE CHILDREN?: AGE?:

OCCUPATION:

HOW LONG DOES IT TAKE YOU TO GET TO WORK?:

HOW DO YOU COMMUTE TO WORK?:

HOURS OF SLEEP:

DO YOU USUALLY HAVE A NAP DURING THE DAY?:

HOW IS YOUR SLEEP PATTERN?:

DO YOU WAKE UP AT NIGHT?:

CAN YOU THINK OF ANY REASON WHY THIS OCCURS?:

DO YOU FEEL YOU HAVE RESTED WHEN YOU WAKE UP?:

DO YOU EXERCISE?: WHAT DO YOU PRACTICE?:

HOW MANY HOURS WEEKLY?:

WHAT INTENSITY?:

OTHER HOBBIES OR INTERESTS:

HOW MANY HOURS WEEKLY?:

ANY FOOD RESTRICTIONS DUE TO ETHNIC OR CULTURAL BELIEFS:

FAMILY BACKGROUND

DIABETES:

HIGH BLOOD PRESSURE:

CARDIOVASCULAR DISEASES:

INFECTIOUS DISEASES:

DIGESTIVE DISORDERS:

CANCER:

KIDNEY DISEASES:

OTHERS:

PERSONAL BACKGROUND

SURGICAL INTERVENTION:

HOSPITALIZATIONS:

ACTUAL MEDICATION:

ALLERGIES:

FOOD INTOLERANCE:

GASTROESOPHAGEAL PATHOLOGY:

GASTROINTESTINAL PATHOLOGY:

METEORISM:

HOW OFTEN DO YOU GO TO THE TOILET:

OTHER RELATED DATA

DO YOU SMOKE?: HOW MANY A DAY?:

ALCOHOL: WHAT KIND?:

QUANTITY: FREQUENCY:

OTHER TOXIC SUBSTANCES:

GYNECOLOGICAL ASPECTS

ARE YOU PREGNANT OR THINK YOU MIGHT BE?:

IF SO, HOW MANY WEEKS?:

AGE AT WHICH THE PERIOD WAS ESTABLISHED:

MENSTRUAL CYCLE DURATION:

DO YOU USE BIRTH CONTROL METHODS?: WHICH ONE?:

MENOPAUSE?: WHEN DID YOUR PERIOD STOP?:

NUTRITIONAL ASPECTS

HAVE YOU SUFFERED WEIGHT CHANGES THROUGHOUT YOUR LIFE?: WHAT AGE?:

DO YOU THINK IT COULD BE RELATED TO ANY SPECIFIC HAPPENING?:

HAVE YOU BEEN ON A DIET BEFORE?: HOW LONG?:

WHO RECOMMENDED?:

DID YOU ACHIEVE THE ESTABLISHED GOALS?:

WHAT DID THE DIET CONSIST ON?

DO YOU CURRENTLY TAKE ANY FOOD SUPPLEMENTS OR VITAMINS?

WHICH ONES?:

HOW OFTEN?

WHO RECOMMENDED?

DIETARY HABITS

HOW MUCH WATER DO YOU DRINK?:

OTHER DRINKS AND QUANTITY:

HOW MANY MEALS A DAY DO YOU USUALLY HAVE?:

HOW MUCH TIME DO YOU DEDICATE TO EACH OF THEM?:

DO YOU CONSIDER THAT YOU EAT FAST?:

HOW MANY DISHES DOES YOUR MENU CONSISTS OF?:

WOULD YOU CLASS YOUR MEALS PORTIONS AS SMALL OR LARGE?:

DO YOU REPEAT?:

DO YOU EAT OUTDOORS?:

WHAT ARE YOUR CHOICES OF RESTAURANTS WHEN YOU GO OUT?:

DO YOU EAT DESSERT?: WHAT'S USUALLY YOUR CHOICE?:

DO YOU DRINK ALCOHOL DURING THE MEALS?:

DO YOU EAT BREAD WITH YOUR MEALS?: HOW MUCH?:

WHAT KIND OF BREAD DO YOU CONSUME?:

WHO COOKS AT HOME?:

WHAT CULINARY METHODS DO YOU USE?:

FOOD PREFERENCES AND/OR DISLIKES:

WHO DOES THE FOOD SHOPPING AT HOME?: WHERE?:

WHAT TIME OF THE DAY?:

HOW OFTEN?:

DO YOU USUALLY HAVE A MENU PROGRAMMED BEFORE GOING TO THE SHOPPING?:

DESCRIBE A STANDARD DAY

WRITE HERE: