CASE HISTORY

IDENTIFICATION NUMBER____
Date: ___/___/___

Identification:

Name: _____

Patient's record number: _____

Birth day: ___/___/___ *Age:*_____

*Education:*_____

Clinical data:

Clinical diagnosis: _____

Metabolic Syndrome diagnosis: _____

Clinical History: _____

Signals and symptoms: _____

_____

*Musculo skeletal Pain: ( ) Não ( ) Sim*_____

Drugs in Use: _____

Antioxidants: _____

Tabacoo use: ( ) no ( )yes, Frequency: _____

Alcoholism: ( ) no ( )yes, Frequency:_____

Blood Pressure: _____

Anthropometric Data

Weight _____kg; Height: _____m;

BMI: _____kg/m^2; Classification: _____;

Waist Circumference: ____cm

Nutritional Data

Recently weight alterations: ( ) no ( )yes,

Observations: _____

Additional observations in relation to the eating habits:_____

_____

Hydric ingestion/day:_____ Recommendation:_____

Food Allergic: ( ) No ( ) yes, Observation:_____