NUTRITION QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with the dietitian. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

PATIENT NAME ____

PATIENT DATE OF BIRTH ____________________________ **TODAY'S DATE** _____________________

What is your goal for today's visit? ____

What is the most difficult issue for you in managing your nutrition? _________________________

WEIGHT HISTORY

Height ________________ **Usual weight** _______________ **Current Weight** _______________

Have you had a recent weight loss _______ **gain** ______

How many meals do you eat per day __________

How many snacks do you eat per day __________

Do you drink alcohol / beer __________

How many times per week __________

How many times per week do you eat out ______________

Are there any food/beverages which you cannot tolerate? Please list ______________________________

Do you smoke? Yes No

If yes, how many packs per day _____________

I quit _____ When did you quit _____________

How much were you smoking ______________

Any food allergies? ____

Do you hide to eat? ___________________

Do you eat when you are sad _______ bored _______ mad _______

How often do you eat the following foods per day:

Milk __________
Fruit __________
Vegetables __________
Juice __________
Snack foods __________

Candy/Chocolate _________
Baked goods _________
Desserts _________
Ice Cream _________
Ethnic Foods _________

Alcohol __________
Coffee/Tea __________
Gatorade/Sports drinks __________
Artificial Sweeteners __________
Fast foods __________

Do any of the following affect your choice of food:

Finances Yes No
Activity Yes No
Eating Out Yes No
Eating Disorder Yes No
Occupation Yes No
Shift work Yes No
Eating in response to stress Yes No
Vitamins Yes No

Grocery shopping Yes No
Meal preparation Yes No
Other food restrictions/allergies Yes No
Breastfeeding Yes No
Prescription drugs Yes No
Alcohol/Other Yes No
Herbal supplements Yes No

What medications do you take? Including diabetes pills or insulin.

Name:	**Dose:**	**Time Taken:**

Over the counter medication, vitamins, herbs, mineral supplement:
