

Nutrition Questionnaire

Date: _____

Please complete this form and bring to your appointment. If a question does not apply, leave it blank. This information will help your dietitian better understand your needs.

Name _____ Date of Birth _____

Address _____

City _____ Zip Code _____

Phone _____ Referring Physician _____

Email _____

Occupation _____

Reason for nutrition consult _____

Please check if you have or have had any of the following condition(s):

- | | | |
|--|---|--|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> prediabetes | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid condition |
| <input type="checkbox"/> gastrointestinal issues | <input type="checkbox"/> gall bladder disease | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> liver disease | <input type="checkbox"/> cancer | <input type="checkbox"/> eating disorder |
| <input type="checkbox"/> migraines | <input type="checkbox"/> irritable bowel syndrome | <input type="checkbox"/> other _____ |

Height: _____ Weight: _____ Typical Blood Pressure _____

Most recent labs (date _____)

Total cholesterol _____ LDL _____ HDL _____ triglycerides _____

Glucose _____ C-reactive protein _____ Hemoglobin A1c _____

Other _____

FAMILY HISTORY

- | | | | |
|--|--|---|---------------------------------|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> heart disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> stroke |
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> cancer (type): _____ | |
| <input type="checkbox"/> thyroid disorder | <input type="checkbox"/> other _____ | | |

Food allergies/sensitivities _____

Current medications _____

Dietary supplements _____

Do you frequently experience any of the following?

- | | | |
|--|--|---|
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> constipation | <input type="checkbox"/> bloating/gas |
| <input type="checkbox"/> dry skin | <input type="checkbox"/> heartburn or reflux | <input type="checkbox"/> light-headed or dizzy |
| <input type="checkbox"/> colds or flu | <input type="checkbox"/> water retention | <input type="checkbox"/> sinus problems |
| <input type="checkbox"/> headaches | <input type="checkbox"/> allergies | <input type="checkbox"/> mood swings |
| <input type="checkbox"/> muscle twitches | <input type="checkbox"/> PMS | <input type="checkbox"/> bleeding gums |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> canker sores | <input type="checkbox"/> tingling in fingers/toes |

Check any that apply:

- My family eats most meals together.
- I eat most of my meals alone.
- Family meals are served at regular times on most days.
- Another member of my family is on a special diet or is trying to lose weight.

How many times in a typical week do you eat:

- | | | |
|---|---|--|
| <input type="checkbox"/> Heat and serve meals _____ | <input type="checkbox"/> Home-cooked meals _____ | <input type="checkbox"/> Fast food _____ |
| <input type="checkbox"/> Restaurant meals _____ | <input type="checkbox"/> Take out (grocery or restaurant) _____ | |

How many hours do you sleep each night, on average? _____

What is the most important goal you want nutrition counseling to help you reach?

Do you have a support system to help you reach your goal(s)?

Are you.... very active somewhat active sedentary very sedentary

What types of exercise or physical activities you participate in *on a regular basis*?

Do you have any limitations for exercise/physical activity?

If weight loss is a goal, please complete the box below.

1. Why is losing weight important for you? _____

2. What is a goal weight (or range) for you? _____

How long ago were you at this weight? _____

What weight (or weight range) would you consider acceptable? _____

3. What have you tried in the past to lose weight:

Diet(s): describe _____

Medication(s): list _____

Other methods: describe _____

4. If you have lost weight in the past:

How much weight did you lose? _____ lbs. over _____ (time)

How much of this weight, if any, did you gain back? _____ lbs.

What plan worked best for you and why? _____

5. Have you ever tried to lose weight with vomiting, diet pills, laxatives or not eating? No Yes

6. Do you often eat when bored, lonely or stressed or anxious? No Yes

7. Do you ever feel out of control when you eat? No Yes