



NUTRITION HISTORY FORM

Please complete this form and bring it to your appointment.

Reason for seeking nutrition advice: _____

How long have you had this health concern/problem: _____

Personal Medical History: Check the conditions that apply.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Autoimmune Condition |
| <input type="checkbox"/> IBS | <input type="checkbox"/> Reflux | <input type="checkbox"/> Insulin Resistance | <input type="checkbox"/> Celiac Disease |
| <input type="checkbox"/> Gallbladder/Liver Condition | <input type="checkbox"/> Thyroid Conditions | <input type="checkbox"/> Abdominal Pain/Bloating | Other: _____ |

Pertinent Family Medical History: _____

Medications currently taking: _____

List any vitamins, minerals, and herbal supplements you are taking: _____

Are you pregnant? Yes/No/Not sure How many months? _____ Due Date: _____

List any problems you had with prior pregnancies: _____

Height: _____ Weight: _____ Usual Weight: _____ Goal Weight: _____

Describe your weight history: _____

Have you ever seen a dietitian/nutritionist before? Explain: _____

Are you currently following a special diet? Explain: _____

Sleep quality on scale from 1-10 (10 being great)? _____ Avg. number hours of sleep? _____

Any food allergies or problem foods? _____

Do you smoke: _____ if yes, how many packs a day? _____

Do you exercise regularly? Yes/No

If so, what type? _____

How often? _____

How would you describe your movement at work? Sedentary Moderately active Very active

NOTES:
(Dietitian use only)

NUTRITION HISTORY FORM CONTINUED

Meal Patterns – How many days per week do you:

a. Eat breakfast?	0-1 day/wk	2-3 days/wk	4-5 days/wk	6-7 days/wk
b. Eat fast food meals?	0-1 day/wk	2-3 days/wk	4-5 days/wk	6-7 days/wk
c. Eat food prepared from outside the house?	0-1 day/wk	2-3 days/wk	4-5 days/wk	6-7 days/wk
d. Eat meals or snacks in front of the tv?	0-1 day/wk	2-3 days/wk	4-5 days/wk	6-7 days/wk
e. Eat meals or snacks in the car?	0-1 day/wk	2-3 days/wk	4-5 days/wk	6-7 days/wk
f. Eat fried foods?	0-1 day/wk	2-3 days/wk	4-5 days/wk	6-7 days/wk

How would you rank your readiness to make lifestyle changes?

1	2	3	4	5	6	7	8	9	10
(not ready)									(very motivated)

NOTES:
(Dietitian use only)

How often do you eat the following food/beverages?
Please check as appropriate.

	Daily	Several times/week	Seldom	Never
Fruits:				
I eat fresh fruit...	___	___	___	___
I eat canned fruit...	___	___	___	___
I eat dried fruit...	___	___	___	___
I drink juice...	___	___	___	___
Vegetables:				
I eat fresh veggies...	___	___	___	___
I eat frozen veggies...	___	___	___	___
I eat canned veggies...	___	___	___	___
Grains:				
I eat whole grains...	___	___	___	___
I eat white flour products...	___	___	___	___
I eat beans/green peas...	___	___	___	___
I eat corn... ___	___	___	___	___
I eat potatoes/sweet potato	___	___	___	___
Yogurt				
I eat yogurt...	___	___	___	___
If so, which type? _____				
Cheese:				
I eat regular white cheese...	___	___	___	___
I eat regular yellow cheese...	___	___	___	___
I eat low fat/fat free cheese...	___	___	___	___
Soy:				
I eat soy products...	___	___	___	___
If so, which type? _____				
Meat:				
I eat beef...	___	___	___	___
I eat pork...	___	___	___	___
I eat chicken...	___	___	___	___
I eat fish...	___	___	___	___
I eat eggs...	___	___	___	___

NUTRITION HISTORY FORM CONTINUED

	Daily	Several times/week	Seldom	Never
Fats:				
I eat butter/margarine...	___	___	___	___
I use oils...	___	___	___	___
I use salad dressing...	___	___	___	___
I eat nuts...	___	___	___	___
I eat nut butter...	___	___	___	___
Sweets:				
I eat sweets...	___	___	___	___
Beverages:				
I drink milk...	___	___	___	___
What kind of milk? _____				
I drink regular sodas...	___	___	___	___
I drink diet sodas...	___	___	___	___
I drink alcohol...	___	___	___	___
If so, what type? _____				
I drink coffee... ___ (# of cups:)	___	___	___	___
What do you add to your coffee? _____				
I drink tea...	___	___	___	___
What type of tea(s)? _____				
I drink regular water...	___	___	___	___
Do you consider your water intake good, fair, or poor? _____				
Other beverage(s): _____				
Artificial Sweeteners:				
I use artificial sweeteners...	___	___	___	___
What type of artificial sweeteners? _____				

NOTES:
(Dietian use only)