lauramangum rd,ld
eat right. be fit. live well.

PEDIATRIC NUTRITION HISTORY FORM

Patient Name:____

Reason for your child's appointment:____

Sex: (circle) Male Female Age: _____ years _____ months

Height _______ Weight ________

Ethnic Group: (circle) African-American Asian Caucasian
Hispanic Other: _________________

Medications?____

Vitamin, Mineral or herbal supplements?____

Please circle the answers to the following questions:

Family History: Do any family members have the following health conditions?

Diabetes	Patient	Parent	Grandparent	Aunt	Uncle	Other
Heart Disease	Patient	Parent	Grandparent	Aunt	Uncle	Other
High Blood Pressure	Patient	Parent	Grandparent	Aunt	Uncle	Other
Obesity	Patient	Parent	Grandparent	Aunt	Uncle	Other
Stroke	Patient	Parent	Grandparent	Aunt	Uncle	Other

Describe your child's quality of sleep:

____

How many hours?______

Naps: Yes/No ______ Daily ______ Weekends only ______ Sporadically

Meal Patterns – how many days per week does the patient:

a. Eat breakfast?

0 – 1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

b. Eat dinner with the family?

0 – 1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

c. Eat "fast food" meals?

0 – 1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

d. Eat meals or snacks in the car?

0 – 1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

e. Eat meals or snacks in front of the tv?

0 – 1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

NOTES:
(Dietian use only)

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Physical Activity – how many days per week does the patient:

a. Participate in physical education?

0 – 1 days/wk   2-3 days/wk   4-5 days/wk

b. Participate in physical activity (walk, ride bike, play games, sports…) for a combined total of 60 minutes?

0 – 1 days/wk   2-3 days/wk   4-5 days/wk   6-7 days/wk

How many hours per day does the patient:

a. Watch tv?

Less than 1 hr/day   1-2 hours   3-4 hours   5 or more hours

b. Use computer and play video games?

Less than 1 hr/day   1-2 hours   3-4 hours   5 or more hours

c. Does the patient have a tv in his/her bedroom?   Yes   No

Questions for Parent/Guardian:

Are you concerned about your weight?   Yes   No

Are you concerned about your childs weight?   Yes   No

How would you rate your family/childs' readiness for change?

1(very resistant)   2   3   4   5   6   7   8   9   10(very motivated)

How often does your child consume 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 potatoes…	____	____	____	____
Yogurt:	____	____	____	____
Cheese:				
I eat regular white cheese…	____	____	____	____
I eat regular yellow cheese…	____	____	____	____
I eat lowfat/fat free cheese…	____	____	____	____
Soy products:	____	____	____	____

If so, which type? ____

	Daily	Several times/week	Seldom	Never
Meat:				
I eat beef…	____	____	____	____
I eat pork…	____	____	____	____
I eat chicken…	____	____	____	____
I eat fish…	____	____	____	____
I eat eggs…	____	____	____	____
Fats:				
I eat butter/margarine…	____	____	____	____
I use oils…	____	____	____	____
I use salad dressing…	____	____	____	____
I eat nuts…	____	____	____	____
I eat peanut butter…	____	____	____	____
Sweets:				
I eat sweets…	____	____	____	____
Artificial Sweeteners:				
I use artificial sweeteners…	____	____	____	____
If so, what type? ______________________________				
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): _________________________________				

NOTES:
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