Nutrition and Health Questionnaire

Date______________

Name___________________________________ Birthdate_______________ Age_________

Medical History

Have you ever had, or do you presently have, any of the following conditions?

Year		Yes	No
_____	high blood cholesterol	☐	☐
_____	high/low blood pressure	☐	☐
_____	heart attach/stroke	☐	☐
_____	obesity/overweight	☐	☐
_____	diabetes	☐	☐
_____	alcohol and/or drug abuse	☐	☐
_____	eating disorder, please specify type__________	☐	☐
_____	depression/anxiety	☐	☐
_____	gastrointestinal problems	☐	☐
_____	osteopenia/osteoporosis	☐	☐
_____	other______________________________	☐	☐

Does anyone in your family have any of the above medical problems? Yes No
If yes, please list family member and problem.
____ ☐ ☐

Are you taking any medications, including over-the-counter drugs (such as aspirin, antacids, diet pills, laxatives, etc.)? If yes, please identify.
____ ☐ ☐

Are you taking any supplemental vitamins, minerals, herbs, or other dietary supplements? If yes, please identify.
____ ☐ ☐

Do you have any food allergies or food intolerances? If yes, please identify.
____ ☐ ☐

Do you have any problems with constipation? ☐ ☐
Do you have any problems with diarrhea? ☐ ☐

The following two questions apply to females only.
Do you have irregular periods? If yes, please describe. ☐ ☐
____
Are you currently taking oral contraceptives/birth control or any other hormone? ☐ ☐
____

Lifestyle Profile

Do you currently smoke? ☐Yes ☐No Do you currently exercise? ☐Yes ☐No
Describe types of exercise____
How many days/week?_____________ How long per session?________________________

How stressful do you consider your life right now? (circle)
1 (not stressful at all) 2 3 4 5 (extremely stressful)

How is your food intake/tolerance affected by stress? (check all that apply)
☐No effect ☐eat more ☐eat less ☐irritable bowel/diarrhea ☐other____________

Weight History
What is your height?________ What is your weight? _______
(if you do not typically weigh yourself, you may give an estimate)
Have you had any recent change in weight? ☐Yes ☐No
If yes, please explain____
What is your highest weight? (>14 yrs for women, >16 yrs for men)_____ Age/year?_____
What is your lowest weight? (>14 yrs for women, >16 yrs for men)_____ Age/year?_____
How do you presently think of yourself? (check one)
☐underweight ☐at your normal weight ☐moderately overweight ☐very overweight
If you would like to gain or lose weight, what would you like to weigh?____________________
Do you weigh yourself? ☐Yes ☐No If yes, how often?___________________________

Nutrition Patterns
Are you following a special diet at this time? ☐Yes ☐No
If yes, please indicate____

Are there any foods that you avoid? ☐Yes ☐No
If yes, which ones____

Do you drink alcoholic beverages? ☐Yes ☐No
If yes, how often? How much?____

Where do you prepare/purchase/eat most of your meals? (check all that apply)
☐Home ☐Fast food ☐Sit down restaurant
☐Cafeteria (school/work) ☐Campus store ☐Vending machine
Do you cook/prepare your own meals? ☐Yes ☐No
Do you primarily eat alone or with others?____

Do you read food labels? If yes, what information on the food label are you focusing on?
____
Do you weigh or measure your foods? If yes, please explain_____________________________
____

Please describe your usual daily eating pattern.

Time	Food/beverage (estimate amount eaten)	Location
_____	____	____________
_____	____	____________
_____	____	____________
_____	____	____________
_____	____	____________
_____	____	____________
_____	____	____________
_____	____	____________
_____	____	____________
_____	____	____________

What specific goals do you want to achieve with this nutritional consultation?
____

Patient signature______________________________________ Date____________________