

Nutrition Questionnaire

Name: _____ Date: _____

Age: ____ Birth Date: _____ Height: _____ Weight: _____

Highest Weight: _____ Lowest Weight: _____ Desired Weight: _____

Diet History: _____

Reason for nutrition visit: _____

How many times a week do you exercise? ____ What do you do? _____

Medical Diagnosis: _____

Pertinent Labs: _____

Medications: _____

Vitamin/Mineral or Herbal Supplements: _____

Food Allergies or Food Intolerances: _____

Are there any foods you avoid or do you follow a special kind of diet? Please explain:

Have you been on diets in the past? Please explain: _____

Please describe a typical day of eating with approximate times and food eaten:

How many times a week do you eat out for the following:

_____ Breakfast _____ Lunch _____ Dinner _____ Snacks

Where do you go? _____

How many times a day do you eat the following foods?

___ Fruits ___ Vegetables ___ Dairy ___ Breads/Cereal/Pasta ___ Nuts ___ Protein

___ Crackers/Pretzels ___ Sweets ___ Soda ___ Coffee/Tea ___ Water ___ Alcohol

What do you think needs to be improved with your eating and what do you see as obstacles?
