FOOD and
NUTRITION
SERVICES

NUTRITION QUESTIONNAIRE

Name: ____

Why are you coming to see the Dietitian? ___________________________________

____

____

Height: ____________ Weight: ____________Age: ____________

Occupation: ____

Are you on a special diet? Yes _____ No _____

If yes, what type? ____

Have you been instructed in diet before? Yes _____ No _____

If yes, what type? ____

____

When and by whom? ____

Have you had any change in appetite? _____________________________________

____

Have you had a recent unexplained weight loss or gain? ________________________

Describe: ____

____

Have you been on a weight loss diet before? Yes _____ No _____

Describe the diet(s) and your success: _____________________________________

____

____

Have you had any surgeries or recent illnesses? Yes _____ No _____

If yes, please specify: ____

____

____

____

Do you have difficulties with:

Swallowing ____ Vomiting ____ Diarrhea ____ Chewing ____

Nausea ____ Constipation ____ Gas/bloating ____

Food Allergies: ____

____

Do you take any vitamin, mineral, herbal or any other supplements? If yes, please list here and please bring product labels or containers with you to your appointment:

____

____

____

Please list any medications you take:

Prescription:

____

____

____

Over the Counter:

____

____

____

Additional Comments:

____

____

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____

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____

Physician's name: ____