SPECIAL DIET CONDITIONS:

_____ Renal
_____ Diabetic
_____ Sodium Restricted
_____ Cholesterol/Fat Restricted
_____ Other _____

Food Allergies [M.D. confirmed]

_____

MEDICAL/PHYSICAL CONDITION

_____ Heart Attack When? _____
_____ Heart Condition/Disease
_____ High Blood Pressure
_____ Pregnant or Nursing Mother

Digestive Problem, explain _____
Anemia _____
Liver Problem _____
Kidney problem _____

What, if any, previous diets have you tried?

_____.

Which, if any, were successful?

_____.

DIETS/ SOCIAL HABITS:

How many meals/snacks do you eat during the day? _____.
How often do you eat outside your home? [i.e., restaurants, dinners, friends/relatives' homes, work, cafeteria, etc.] _____.
Who is the family member responsible for food preparation in your household?

_____.

Do you currently smoke cigarettes? Yes_____ No_____ or have you quit smoking _____? If so, for how long? _____.
Do you drink caffeinated beverages? [coffee, tea, colas, etc.] Yes____ No___ Servings per day: _____.
Do you drink alcoholic beverages? Yes ____ No____ Type: _____.
Frequency: _____.
Are you taking any prescription medication? Yes____ No_____ Name of Medication:

_____.

Do you take vitamins or nutritional supplements?

_____.