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Outpatient Nutrition Clinic Questionnaire

Name: _____ Date:_____

Date of Birth:_____ Sex: M / F Height:_____ Current Weight:_____

1. Has your weight changed in the last six months? If so, how much?
   ☐ No change ☐ Lost_____ pounds in _____weeks ☐ Gained_____pounds in_____weeks
2. Are you currently following a special diet? ☐ Yes ☐ No
   If so, type of diet:_____ How long?_____
3. Have you ever received nutrition education from a Registered Dietitian? ☐ Yes ☐ No When?_____
4. Do you exercise? ☐ Yes ☐ No. If yes, how many times per week:_____ for how long?_____
   What type of exercise do you do? _____
5. Check which of the following conditions apply to you and list the medications you are taking:
   ☐ High Blood Pressure: Meds:_____
   ☐ High Cholesterol: Meds:_____
   ☐ Diabetes: Meds:_____
6. Other meds: _____
7. Are you taking any over-the-counter supplements, to include vitamins/minerals/herbals? ☐ Yes ☐ No
   ☐ Multi-vitamin ☐ Other: _____
8. Do you have any food allergies/intolerances or cultural/religious food preferences? ☐ Yes ☐ No
   Describe: _____
9. Do you have GI issues? ☐ GERD ☐ Constipation ☐ Diarrhea ☐ Other: _____
10. Do you have trouble chewing or swallowing? ☐ Yes ☐ No
11. Do you smoke or use smokeless tobacco? ☐ Yes ☐ No What? _____ Packs/day? _____
12. Do you drink alcohol? ☐ Yes ☐ No What? _____ Amount _____ /day _____/week

DIET HISTORY:

1. How many meals do you eat per day?_____. Do you eat snacks between meals? ☐ Yes ☐ No
   If yes, what type of foods do you snack on?_____
2. How do you cook most of your foods? ☐ Fry ☐ Bake ☐ Convenience ☐ I don't cook at home

3. Who does the food prep/shopping? ☐ Self ☐ Other _____ ☐ Don't shop

4. How many times do you eat/take out per week? _____ Which meal(s)? _____

Type of restaurants? _____

5. What type of beverages do you drink:

Item	Amount per Day	Item	Amount per Day
Regular Soda	_____	Milk (type:_____)	_____
Diet Soda	_____	Coffee	_____
Water	_____	Fruit Juice	_____
Tea	_____	Koolaid	_____
Other	_____	Crystal Light	_____

6. If you did not keep a food record please write down everything you consumed in the last 24 hours in the space below. Please include portion sizes, condiments and beverages:

Breakfast Mid Morning Snack Lunch

Afternoon Snack Dinner Bed Time Snack

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BMI _____ REE _____ x Activity _____ = _____kcal/day to maintain

Estimated energy needs to gain/lose:_____