Bryn Arata
NUTRITION

Nutrition Questionnaire

Name:_____Date of birth:_____Date:_____

Reason for Nutrition Evaluation:_____

_____

List any previous or current medical issues:_____

List any food allergies or intolerances:_____

Have you experienced any recent weight gain or loss? Y N

If yes, how much in how long?_____

Please lists any medications, nutrition supplements or vitamins that your are currently taking:_____

For pediatric patients only:

Birth History:

Weeks gestation:_____ Birth weight:_____Birth Length:_____

Family History:

Obesity_____Cardiovascular disease_____High Blood Pressure_____Stroke_____

High Cholesterol_____High Trigycerides_____ Diabetes, Type 1_____ Diabetes, Type 2_____

Liver disease_____Thyroid Disease_____ Celiac Disease_____ Food Allergies_____

Cystic Fibrosis_____ Other:_____

For pediatric patients only:

Social History:

Who is living at home with your child?_____

Who is with your child before school?_____After School?_____Wkend?_____

Who is responsible for meal preparation?_____

Do you send in meals and snacks to school?_____

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Diet History:

How many meals do you eat per day?_____ Snacks?_____

Are meals and snacks at scheduled times?_____

Please list meal and snack times:_____

Where are meals eaten?_____

Who are meals eaten with?_____

How long do meals last?_____

How many times do you dine out per week?_____

Please list examples of where you dine out:_____

Please provide a brief diet recall of what you eat for meals and snacks on a typical day:

_____

_____

_____

_____

_____

Activity:

How many hours per day do you sit at computer or watch TV:_____

How many hours a day are you active:_____

Do you exercise on a regular basis?_____If yes, what do you do?_____

_____

Additional comments: