*Patient Name*_____ *Date*_____

Nutrition History Form

Height:_____ Weight:_____ Blood Pressure:_____ Age:_____

How would you describe your eating habits? □ Excellent □ Good □ Fair □ Poor

What do you want to change about your diet?_____
_____
_____
_____

Are you on a diet right now? (If yes, explain)_____
_____
_____
_____

Do you diet frequently?_____

What foods do you like?_____
_____
_____
_____

What foods do you dislike?_____
_____
_____
_____

Do you have any food cravings? If yes, what foods?_____
_____
_____
_____

How many times per week do you dine out for: Breakfast?_____ Lunch?_____
Dinner?_____

What type of restaurants?_____
_____
_____

What triggers you to eat? (Please check all that apply)

□ Boredom □ Emotions □ Hunger □ Seeing/Smelling Food □ Time of day

□Physical Activity

*Patient Name*_____ *Date*_____

Do you have a history of an eating disorder? □ Anorexia □ Bulimia □ Binge Eating

(If yes, please explain) _____
_____
_____
_____

Do you drink □ With meals □ In between meals □ Before meals □ After meals

How many eight once glasses of water do you consume daily?_____

Do you regularly eat:

Breakfast? □ Yes □ No Sample of a typical breakfast:_____
_____
_____
Time:_____

Lunch? □ Yes □ No Sample of a typical lunch:_____
_____
_____
Time:_____

Dinner? □ Yes □ No Sample of a typical dinner:_____
_____
_____
Time:_____

Snacks? □ Yes □ No Sample of a typical snack:_____
_____
_____
Time(s):_____

Are you a:

□ Vegetarian □ Vegan □ Lacto-ovo Vegetarian (Dairy and eggs) □ Flexitarian

□ Pescatarian (Fish only) □ Lacto-Vegetarian (Dairy only) □ Ovo-Vegetarian (Eggs only)

*Patient Name*_____ *Date*_____

Food Intake Record

Please indicate which foods you eat.

Foods	Less than once a week	Not daily but at least once a week	Daily
Milk, yogurt			
Milk Substitutes: (Circle which) Almond, Coconut, Flaxseed, Rice, Soy, Sunflower			
Cheese			
Red Meat			
Poultry			
Fish			
Eggs			
Mixed Dishes			
Dried Legumes			
Peanut Butter			
Nuts			
Breads, cereal			
Potatoes, pasta, rice			
Crackers, chips, etc.			
Fruits, juices			
Vegetables			
Margarine, butter			
Oils (Circle which) Olive, Canola, Corn, Vegetable, Coconut, Safflower, Sunflower, Soy, Grapeseed, Flaxseed, other:_____			
Salad dressing (What kind?_____)			
Ice cream			
Cookies, cake, pie			
Candy			
Soft Drink			
Coffee			
Tea, iced tea			
Tofu			
Alcohol (type:_____)			

*Patient Name*_____ *Date*_____

Supplements/Vitamins

Do you take supplements/Vitamins daily?

□ Yes □ No

If yes, please list:

Vitamin/Supplement	Dose	Brand Name

Physical Activity Questionnaire

Do you exercise? □ Yes □ No
If yes, what kind of exercise do you participate in?_____
_____
_____

How often?_____

When exercising, do you feel the following? (Please check all that apply)

□ Shortness of Breath
□ Chest Pain
□ Joint Pain
□ Muscle Soreness
□ Dizziness