Nutrition and Eating Habits Questionnaire

Name _____ Date _____

Phone _____ Email _____

Physician:_____

Date of Birth:_____ Height: _____ Weight: _____(can leave blank)

Employee:_____ Dependent BSBS eligible:_____ Student:_____

Would you like to have a SECA body composition test: Yes_____ No_____
(There is no additional charge for this test)
Is it okay to have a pet therapy dog in session? Yes_____ No_____

What is the first thing that comes to mind when you think about your eating habits?

Do you like to cook? _____

Who prepares meals in your home? _____

How many meals do you eat away from home on weekdays? _____

How many breakfasts? _____Lunches? _____ Evening Meals? _____

How many meals do you eat away from home on weekends? _____

How many breakfasts?_____ Lunches?_____ Evening Meals?_____

List restaurants where you often eat:

_____

_____

Do you exercise? No_____ Yes_____

If you do exercise, what do you do? How often do you it?

Is there any reason why you cannot or should not exercise?

Has your weight changed in the last year? (Can leave the next 3 questions blank)

No_____
Yes, I gained ____ pounds
Yes, I lost ____ pounds

What do you think is a realistic weight for you? _____ pounds

How long has it been since you were at that (realistic) weight?

Do you currently take any medicines?

No _____Yes _____

If you do, list them:

Have you ever tried medicine to lose weight?

No_____ Yes_____

If you have, list the medicines:

What kind of diets have you tried to lose or gain weight?

_____

Do you currently take vitamins?

No_____ Yes_____

If you do, list them with the amounts that you take:

_____

_____

Do you use any other dietary supplements? (Supplements include over the counter herbs, fiber, and sports drinks).

No_____ Yes_____

If you do, list the supplements with the amounts that you take:

_____

_____

Do you use any meal replacement products (drinks, bars, formulas, etc.)?

No_____ Yes_____

If you do, list the types and how often you take them:

_____

_____

What kind of beverages do you drink on most days? List the amounts that you typically drink in one day.

Coffee_____ Tea_____ Juice_____
Regular soda____ Diet soda_____ Water_____
Milk: Whole____ 2%_____1% _____Nonfat (skim)_____
Alcohol (list type and number of drinks)_____
Other (list type and number of drinks)_____

Do you have any food allergies?

Please list any foods you dislike or will not eat:

Are family members supportive to dietary/lifestyle changes?

Are friends supportive to dietary/lifestyle changes?

Is there anything else that you want the dietitian to know?

UNIVERSITY HEALTH SERVICES