lifestyle medicine center
MIDLAND HEALTH

Adult Nutrition Questionnaire

To give you personalized care and attention, the dietitian needs to know a little bit about you and your lifestyle. Please take a few minutes to answer the following questions.

Name:	**Date of Birth:**

Age:	**Height:**	**Weight:**

General Information

What do you hope to accomplish from this appointment?_____
_____
_____

Do you have any drug allergies? Yes☐ No☐

_____

Do you currently take any medications? Yes☐ No☐

If yes, please list:
_____
_____
_____

Do you currently take any vitamins or supplements? Yes☐ No☐

If yes, please list:
_____
_____
_____

Do you use tobacco products? Yes☐ No☐ If yes, how much? _____

Do you drink alcohol? Yes☐ No☐ If yes how often do you drink alcohol?

☐0-1 times/month ☐ 2-3 times/month ☐ 1-2 times/week ☐3-4 times/week ☐ 5+ times/week

Do you use illicit drugs? Yes☐ No☐ If yes, which one? _____

What is your health history? (Check all that apply:)

☐Heart disease ☐ High blood pressure

☐ Diabetes ☐ High cholesterol

☐ Cancer ☐ Other_____

Weight History

Has your weight changed in the past year? ☐ Yes ☐ No If yes how much weight have you gained or lost?_____

Are you trying lose or gain weight? ☐ Yes ☐ No If yes, what is your goal weight_____

Have you ever used weight loss medications ☐ Yes ☐ No If yes, what medications have you used_____
_____

Have you had weight loss surgery? ☐ Yes ☐ No If yes, what type of surgery have you had?
_____

Have you tried any alternative therapies for weight loss(i.e. acupuncture, nutritionist)? ☐ Yes ☐ No If yes, which alternative therapies_____

Have you ever purposefully restricted food intake and obtained what you or others felt was an extremely low or unhealthy weight? Yes ☐ No ☐

If yes, please explain: _____

Have you ever thrown up, used laxatives, fasted, or exercised for long periods of time to lose weight?

Yes ☐ No ☐ If yes, please explain: _____

Diet History

How would you rate current eating habits? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Which commercial or fad diets have you tried in the past? Check all that apply

☐ Atkins	☐ Low fat	☐ Low Carb
☐ CHIP	☐ South Beach	☐ Paleo
☐ Mediterranean Diet	☐ Elimination Diet (Allergy)	☐ Vegan
☐ Jenny Craig	☐ Weight Watchers	☐ Vegetarian
☐ D.A.S.H	☐ Gluten Free	☐ Slim Fast/Meal Replacements

Other:_____

Eating Patterns

How many meals do you usually eat per day? ☐ 0-1 ☐ 2-3 ☐ 4+

How many snacks do you usually eat per day? ☐ 0-1 ☐ 2-3 ☐ 4+

How often do you skip meals? ☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Do you have any food intolerances or sensitivities? ☐ Yes ☐ No If yes_____

What type of food do you like?_____

What are you food dislikes?_____

How much water do you drink per day (8 oz cups)?_____

On average how many cups (8oz.) of caffeinated beverages do you drink per day (tea, soda, coffee or energy drinks)?_____

On average how many cups (8oz.) of sugary drinks (soda, sports drinks, juices) do you drink per day?_____

On average how often do you snack on convenience food (chips, candy, granola bars, crackers, cookies)

☐ Never ☐ Seldom ☐ Sometimes ☐Often ☐ Always

How often do you eat out per week (fast food or restaurants) ☐ 0-1 ☐ 2-4 ☐ 5 or more

Who does the grocery shopping? ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

Who does the meal preparation and cooking? ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

Would you consider yourself an emotional eater? ☐Yes ☐No

If yes, what triggers you? ☐ Sadness ☐Anxiety ☐Stress ☐Boredom ☐Anger

Which of the following factors apply to you eating habits and current lifestyle? Check all that apply

☐ Likes healthy food	☐ Dislikes healthy food	☐ Reads nutrition labels
☐ Fast eater	☐ Eat slowly	☐ Prepare meals at home
☐ Rely on packaged/fast food	☐ Likes cooking	☐ Dislikes cooking
☐ Do not know how to cook	☐ Knows how to cook	☐ No time to prepare meals/snacks
☐ Plans Meals	☐ Do not plan meals	☐ Eats a variety of foods
☐ Late night eater	☐ Eats most meals at table	☐ Eats while watching TV/Computer
☐ Lives alone/eats alone		

Physical Activity

Do you currently exercise? Yes ☐ No ☐

What type of exercise?_____ How many times?_____days/week How long? _____minutes/day

Do you have any exercise limitations? Yes ☐No ☐ If yes, please describe_____

How much time do you spend on the screen (computer/TV/Phone)?_____hrs