

Amy C. Bluntzer, RD, LD
Nutrition Counseling

Nutrition History

Please complete this questionnaire and bring it to your first appointment.

Name: _____ Date: _____

Date of Birth: ____/____/____

Reason for seeing a dietitian: _____

Other health-related goals: _____

Rate your readiness for change 1(not ready) to 10 (already making a lot of changes):

Circle: 1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Personal Medical History: Check conditions you have or have had.

____ Heart disease or stroke	____ Diabetes	____ Ulcer
____ High blood pressure	____ Obesity/severe overweight	____ Nausea/vomiting
____ High Triglycerides	____ Lung problems	____ Constipation
____ High Cholesterol	____ Anemia	____ Diarrhea
____ Cancer	____ Eating disorder	____ Abdominal pain/bloating
____ Food Allergies/Sensitivities	____ Arthritis	____ Other: _____

Family Medical History: Check conditions that apply to your blood relatives including parents, grandparents, brothers, sisters, and children.

____ Heart disease or stroke	____ Diabetes	____ Ulcer
____ High blood pressure	____ Obesity/severe overweight	____ Nausea/vomiting
____ High Triglycerides	____ Lung problems	____ Constipation
____ High Cholesterol	____ Anemia	____ Diarrhea
____ Cancer	____ Eating disorder	____ Abdominal pain/bloating
____ Food Allergies/Sensitivities	____ Arthritis	____ Other: _____

Please bring a copy of current pertinent lab work (cholesterol, triglycerides, etc.)

List all medications you are taking: _____

List all vitamin, mineral, and herbal supplements you are taking: _____

Height: _____ Present Weight: _____ Usual weight: _____ Goal Weight: _____

Have you ever tried to change your diet before? ___ Explain: _____

Food dislikes or food that you have a problem eating: _____

Occupation: _____

List all those who live in your home and indicate any special dietary needs:

Who prepares meals? _____

Who shops for groceries? _____

How often do you eat out each week? _____ Where? _____

Alcohol intake: _____ drinks per day _____ drinks per week

Tobacco Intake: _____ non smoker _____ quit smoking _____ packs per day

Exercise: Yes/ No. If Yes, frequency _____ Type: _____

If No, what type of exercise do you think you would enjoy? _____

Other comments or concerns: _____

Please attach a 3 day food record. Include the time, food or drink consumed, and approximate portion size. If possible include one weekend day. Be as detailed as possible.

Example:

*Monday 7:30 AM 1 Eggo waffle
 1 cup vanilla yogurt
 1 cup coffee with 1 tsp. sugar*

10:00 AM 4 peanut butter crackers and water

*12:45 PM Wendy's grilled chicken sandwich,
 French fries, regular
 Diet coke*

3:30 PM 1 handful animal crackers and juice box

*6:30 PM 2 palm-size slices roast beef
 1 cup potatoes and carrots
 1 roll, white no butter*

10:00 PM ½ cup chocolate ice cream