lauramangum rd,ld
eat right. be fit. live well.

NUTRITION HISTORY FORM

Please complete this form and bring it to your appointment.

Reason for seeking nutrition advice: ______________________________

How long have you had this health concern/problem: ______________________________

Personal Medical History: Check the conditions that apply.

- ___ Heart Disease
- ___ High Triglycerides
- ___ High Cholesterol
- ___ Eating Disorder
- ___ IBS
- ___ Gallbladder/Liver Condition
- ___ Diabetes
- ___ Ulcer
- ___ Anemia
- ___ Arthritis
- ___ Reflux
- ___ Thyroid Conditions
- ___ High Blood Pressure
- ___ Nausea/Vomiting
- ___ Cancer
- ___ Food Allergies and/ or sensitivities
- ___ Insulin Resistance
- ___ Abdominal Pain/Bloating
- ___ Obesity
- ___ Diarrhea/Constipation
- ___ Neurological Disorder
- ___ Autoimmune Condition
- ___ Celiac Disease
- ___ Other: ______________________________

Pertinent Family Medical History: ______________________________

Medications currently taking: ______________________________

____

List any vitamins, minerals, and herbal supplements you are taking: ______________________________

____

Are you pregnant? Yes/No/Not sure How many months? __________ Due Date: ____________

List any problems you had with prior pregnancies: ______________________________

Height: _________ Weight: _________ Usual Weight: _________ Goal Weight: _________

Describe your weight history: ______________________________

Have you ever seen a dietitian/nutritionist before? Explain: ______________________________

Are you currently following a special diet? Explain: ______________________________

Sleep quality on scale from 1-10 (10 being great)? _______ Avg. number hours of sleep? ______

Do you smoke: ___________ if yes, how many packs a day? _______________

Do you exercise regularly? Yes/No

If so, what type? ______________________________

How often? ______________________________

How would you describe your movement at work? Sedentary Moderately active Very active

NOTES:
(Dietitian use only)

Meal Patterns – How many days per week do you:

a.	Eat breakfast?	0-1 day/wk	2-3 days/wk	4-5 days/wk	6-7 days/wk
b.	Eat fast food meals?	0-1 day/wk	2-3 days/wk	4-5 days/wk	6-7 days/wk
c.	Eat food prepared from outside the house?	0-1 day/wk	2-3 days/wk	4-5 days/wk	6-7 days/wk
d.	Eat meals or snacks in front of the tv?	0-1 day/wk	2-3 days/wk	4-5 days/wk	6-7 days/wk
e.	Eat meals or snacks in the car?	0-1 day/wk	2-3 days/wk	4-5 days/wk	6-7 days/wk
f.	Eat fried foods?	0-1 day/wk	2-3 days/wk	4-5 days/wk	6-7 days/wk

How would you rank your readiness to make lifestyle changes?

1	2	3	4	5	6	7	8	9	10
(not ready)									(very motivated)

Any food allergies or sensitivities? ______________________________

How often do you eat the following food/beverages?

Please check as appropriate.

		Daily	Several times/week	Occasional	Never
Fruits:	I eat fresh fruit…	____	____	____	____
	I eat canned fruit…	____	____	____	____
	I eat dried fruit…	____	____	____	____
Vegetables:					
	I eat fresh veggies…	____	____	____	____
	I eat frozen veggies…	____	____	____	____
	I eat canned veggies…	____	____	____	____
Grains:	I eat whole grains (wheat rice, quinoa, etc)…	____	____	____	____
	I eat white flour products…	____	____	____	____
	I eat legumes/lentils/peas…	____	____	____	____
	I eat corn/corn products…	____	____	____	
	I eat potatoes/sweet potato	____	____	____	____
	I eat winter squash (butternut, acorn, spaghetti)…	____	____	____	____
Yogurt					
	I eat yogurt…	____	____	____	____
	If so, which type? ____________________				
Cheese:					
	I eat regular white cheese…	____	____	____	____
	I eat regular yellow cheese…	____	____	____	____
	I eat low fat/fat free cheese…	____	____	____	____
Soy:					
	I eat soy products…	____	____	____	____
	If so, which type? ____________________				
Meat:					
	I eat beef…	____	____	____	____
	I eat pork…	____	____	____	____
	I eat chicken/turkey…	____	____	____	____
	I eat fish…	____	____	____	____
	I eat eggs…	____	____	____	____

NOTES:
(Dietitian use only)

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	Daily	Several times/week	Occasional	Never
Fats:				
I eat butter/margarine…	____	____	____	____
I use oils…	____	____	____	____
If so, what type? ____________				
I use salad dressing…	____	____	____	____
I eat nuts…	____	____	____	____
I eat peanut or nut butter…	____	____	____	____
I eat avocados…	____	____	____	____
I eat olives…	____	____	____	____
I eat hummus…	____	____	____	____
Sweets:				
I eat sweets…	____	____	____	____
Beverages:				
I drink milk…	____	____	____	____
What kind of milk? ____________				
I drink regular sodas…	____	____	____	____
I drink diet sodas…	____	____	____	____
I drink alcohol…	____	____	____	____
If so, what type? ____________				
I drink coffee… ____ (# of cups:)	____	____	____	____
What do you add to your coffee? ____________				
I drink tea…	____	____	____	____
What type of tea(s)? ____________				
What do you add to your tea? ____________				
I drink regular water…	____	____	____	____

Do you consider your water intake good, fair, or poor? ____________

Other beverages:

If you drink the following regularly, please circle:

carbonated water *energy drinks* *fruit juice*

	Daily	Several times/week	Occasional	Never
Artificial/Alternative Sweeteners:				
I use other sweeteners than sugar…	____	____	____	____

What type of sweeteners? ____________