_____ _____

Name Date

Food History Questionnaire

The following questions and answers are designed to help me evaluate your eating habits and make dietary recommendations that will be tailored to you or your medical problem. At your appointment, I will go into more detail as it applies to you. Please bring this form, completed, to the appointment.

Please feel free to bring your spouse, good friend, relative or anyone who is involved with cooking and eating with you. Thank you—Ann M. Del Tredici, MS, RD, CDE

Please CIRCLE and FILL IN your answers:

1. Why are you coming to see a Registered Dietitian/Nutritionist? _____

_____

2. Are you on a special diet now? (like a low sodium, diabetic, low cholesterol or weight loss diet)

YES / NO If yes, please describe: _____

_____

3. Do you consider your weight ideal? **YES / NO** Your current weight: _____pounds

Your Height: _____ft _____in Your high school/college weight? _____ pounds

If your weight is not ideal, what would you like to weigh? _____ pounds

Your goal to **Lose:** _____pounds **Or** Your goal to **Gain:**_____ pounds

4. Who cooks your meals? **Self / Spouse / Friend / Parent / Child / Restaurant**

Frozen Food / Take Out / Private Chef / Delivery or **Other: _____**

5. Who shops for food in your household? **Self / Spouse / Friend / Other**_____

6. How often do you eat in **Restaurants** and/or pick-up **Take Out** food? (commercially made food)

Breakfast: _____times/wk **Lunch: _____**times/wk **Dinner:** _____times/wk

7. Do you drink alcohol? **YES / NO** If yes, how much do you drink of the following?

Wine _____glass/day **Beer: _____**/day **Liquor:** _____oz/day (Type:_____)

8. Are you a vegetarian? **YES / NO / USUALLY** If yes, for how long? _____months or years

If you are a vegetarian, are there any animal proteins you eat? (circle any)

Eggs Egg Whites Milk Cheese Yogurt Fish Shellfish Chicken Other_____

9. Are you a vegan? **YES / NO / MOST OF THE TIME** If yes, for how long? _____months or years

Please continue on Page 2

10. If you are **not** a vegetarian or vegan and do eat animal proteins, how often do you eat them?

Red Meat (beef, lamb, pork) _____/week **Chicken or Turkey** _____/week

Fish and Shellfish _____/week **Milk** _____/week (% fat milk: _____%)

Cheese _____ounces/week (circle any: **Regular fat** cheese **Low fat** cheese **Fat Free** cheese)

Whole Eggs _____/week **Egg Whites** _____/week

Yogurt_____/week (% fat yogurt:_____%) (circle: **Regular Greek Both** types yogurt)

11. Do you use butter? **YES / NO** If yes, how much? _____/day

Regular margarine? **YES / NO** If yes, how much? _____/day Brand:_____

Diet margarine/butter spray? **YES / NO** If yes, how much? _____/day Brand:_____

Oil? **YES / NO** If yes, how much? _____/day Type of oil:_____

Mayonnaise? **YES / NO** If yes, how much? _____/day Brand:_____

Salad Dressing? **YES / NO** If yes, how much? _____/day Type:_____

Pam/Vegetable oil spray? **YES / NO**

12. Do you add salt to your food? **YES / NO / SOMETIMES**

13. Do you have a "sweet tooth?" (crave sweets?) **YES / NO** When?_____

14. Do you avoid carbohydrates? **YES / NO** If yes, why?_____

15. Do you limit your carbohydrate intake? **YES / NO** To how much?_____

16. Do you drink fruit juice or sugar-sweetened beverages? **YES / NO** How often?_____/week

17. Do you use artificial sweeteners? **YES / NO** If yes, which ones?_____

18. Your favorite fruit(s):_____

19. Your favorite vegetable(s):_____

20. Your favorite food:_____

21. Are you an "emotional eater?" **YES / NO** When?_____

22. Do you drink coffee? **Regular / Decaffeinated / NO** If yes,_____ cups/day

Please continue on Page 3

23. Do you drink tea? **YES / NO** If yes, what kind? _____ & _____cups/day

24. Do you eat gluten? **YES / NO** If no, why?_____

25. Do you have any food allergies? **YES / NO** If yes, to what?_____

_____

26. List foods you would find it hard to do without: _____

_____

27. Describe what foods you might typically eat at these meals:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

_____

28. Are you currently engaged in regular exercise? **YES / NO** If yes, please describe what exercise:_____ How often? _____/week

29. Have you ever seen a Registered Dietitian or Nutritionist before? **YES / NO**

If yes, for what reason?_____

30. If you take medications, please list them here—or please bring in a copy of your medication list.

End

