TMH PHYSICIAN PARTNERS

TALLAHASSEE MEMORIAL DIABETES SERVICES

NUTRITION QUESTIONNAIRE

Name: _____ DOB: ____/____/____

Occupation: _____ Work hours: _____

Please check any recent major stresses:
□ recently married □ recently divorced □ death in family □ job change □ other: _____

Are you in a family situation where you fear for your safety? □ Yes □ No
How many people in your household, including you? _____

MEDICAL HISTORY
Please check YES or NO to any of the following medical conditions that apply to you:

High Blood Pressure	□ No	□ Yes	Heart Disease	□ No	□ Yes
Stroke	□ No	□ Yes	Kidney disease	□ No	□ Yes
Constipation	□ No	□ Yes	Indigestion	□ No	□ Yes
Diarrhea	□ No	□ Yes	Chronic pain	□ No	□ Yes
Diabetes	□ No	□ Yes	Pre-diabetes	□ No	□ Yes

Please list any other health problems that you have:_____
Have you been hospitalized in the past year? □ No □ Yes If yes, for what? _____

Do you smoke or chew tobacco? □ No □ Yes, how often? _____ How much? _____
Do you have any religious, cultural or personal health beliefs that you would like us to consider as we develop your therapy or meal plan? _____

Do you drink alcohol? □ No □ Yes, how often? _____ How much? _____

PHYSICAL ACTIVITY HISTORY:
What type of exercise do you do regularly and how much time each week do you spend doing them?
(ex. Walking, swimming, biking, etc.)

Activity	Days per week	Minutes per activity
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you perform other physical activities of daily living, such as housework, gardening, or climbing stairs?
□ No □ Yes, type and amount:_____

Have you been advised to exercise by your physician? □ No □ Yes Restrictions? _____
Have you ever seen a Dietitian?_____
Are you following any type of meal plan/diet, such as calorie or carbohydrate counting, low-carbohydrate, low-cholesterol, low- sodium or low fat? □ No □ Yes, explain: _____

Which diets have you tried in the past? _____

Who does the shopping/cooking? _____

OVER

TMH PHYSICIAN PARTNERS

Name_____DOB_____

Please describe below what you typically eat in a 24 –hour period:
Breakfast – Time: _____ AM/PM Food/drink: _____
Lunch – Time: _____ AM/PM Food/drink: _____
Dinner – Time: _____ AM/PM Food/drink: _____
Snacks – Time: _____ AM/PM Food/drink: _____

Please check approximately how often you eat the following foods:

High fat meats like sausage, bacon, hot dogs and ribs:
❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

Whole milk, cream, cheese, ice cream:
❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

Fish:
❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

How is your fish usually cooked?_____How is your meat usually cooked?_____

Sweets like candy, cakes, cookies, pies:

❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

Vegetables like greens, broccoli, lettuce, cabbage, green beans, and carrots:

❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

Whole grains like oatmeal, cheerios, whole wheat bread or brown rice:

❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

Do you drink sugar sweetened drinks like soda, Gatorade, Kool-Ade or sweet tea?

❒ Almost every day ❒ 2-3 times/week ❒ once/week ❒ occasionally ❒ Never ❒ other_____

Please list any food allergies: _____

What information would you like from the dietitian?

□ Meal planning □ How to lower cholesterol □ Grocery shopping □ Weight management
□ Record keeping □ Eating out □ Exercise □ Food label reading
□ Other: _____

DIETITIAN SIGNATURE_____**DATE/TIME:**_____
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