TALLAHASSEE MEMORIAL DIABETES SERVICES
850 431-5404/FAX 850 431-4838

Pediatric Nutrition Questionnaire

Patient Name_____ DOB _____ Race_____

Please specify any religious/cultural or personal health beliefs that you would like us to consider as we help you develop your child's nutrition care plan:

_____

What language do you prefer using in discussing your child's health care? ❑English ❑Other:_____

Parent/Guardian Information:

Name_____Relationship_____ Occupation_____

Phone: Home_____Work_____ Cell_____

Name_____Relationship_____ Occupation_____

Phone: Home_____Work_____ Cell_____

Child lives with (please give name, age, and relationship):

_____

Child's school or daycare _____ Grade _____ Hours at school_____

Does your child have any food or medication allergies? ❑No ❑Yes If yes, please specify:_____

_____

Does your child or any other family member have any of the following health problems?

Anxiety/depression ❑No ❑Yes If yes, who?_____
Asthma ❑No ❑Yes If yes, who?_____
Celiac disease ❑No ❑Yes If yes, who?_____
Constipation/diarrhea ❑No ❑Yes If yes, who?_____
Diabetes ❑No ❑Yes If yes, who?_____
Heart disease ❑No ❑Yes If yes, who?_____
High cholesterol ❑No ❑Yes If yes, who?_____
High blood pressure ❑No ❑Yes If yes, who?_____
Kidney disease ❑No ❑Yes If yes, who?_____

Other medical information that may help us better know your child: _____

Social History:

Please describe any personal or family events or concerns that we should be aware of, such as divorce, moving, school problems.

_____

_____

Does your child use alcohol, tobacco, or recreational drugs? ❑No ❑Yes If yes, please explain _____

Are you or your child in a situation in which you fear for your safety? ❑No ❑Yes

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Patient Name_____ **DOB** _____.

Exercise and Activity:

List your child's sports or extracurricular activities: _____

List any physical limitations of your child: _____

Growth History:

Child's birth weight _____ Child's birth length_____
Mother's weight _____ Mother's height_____ Father's weight_____ Father's height_____

Please describe any changes or concerns about your child's growth pattern: _____
_____

Do you have any concerns about the food choices of your child or family? ❑No ❑Yes If yes, please explain _____
_____

Are you or any members of your family currently on any type of meal plan or diet? ❑No ❑Yes
If yes, please describe _____

Who does most of the cooking and grocery shopping in your home? _____

Are there any food practices that we should know about? (such as vegetarian, no pork) _____

Child's favorite beverages: _____

Usual Daily Schedule:

	Where is the child usually? (school, home, grandma's, etc)	Sit down family meal or eaten "on the run"?	Typical Foods
Breakfast Time _____	_____	_____	_____
Lunch Time _____	_____	_____	_____
Dinner Time _____	_____	_____	_____

Snacks: What?_____ When _____

Signature of person filling out form_____

Relationship to patient_____ Date_____

DIETITIAN'S SIGNATURE _____ **DATE/TIME**_____

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