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
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:_________________