



Food & Medical History Questionnaire

Dietary History

Have you ever tried to lose weight before? yes no

1. Type of Diet: _____

Short-term results? _____

Long-term results? _____

2. Type of Diet: _____

Short-term results? _____

Long-term results? _____

3. Type of Diet: _____

Short-term results? _____

Long-term results? _____

Additional comments you would like to add regarding "dieting" history?

Have you ever used laxatives for weight control? yes no

Have you ever vomited for weight control? yes no

Personal Medical History

Please list any medical diagnoses or procedures which have affected your appetite, caused weight gain/loss, or required management with medical nutrition therapy, i.e. diabetes

If you have recent laboratory test results, please list:

Date _____

Total Cholesterol _____
Triglycerides _____
LDL _____
HDL _____
Glucose _____
Blood Pressure _____
Other _____

Current medications and dosage:

Have you ever been advised by your physician to follow a special diet?
(low salt, low cholesterol, no sugar, etc) yes no

What changes did you make at that time?

Have you ever worked with a dietitian/nutritionist? yes no
If yes, what was your experience? _____

Rate your health: excellent good fair poor

Personal Health History

Do you take any vitamin, mineral, or food supplements? yes no
If yes, what type and dose?

Do you have any food allergies? yes no
If yes, please specify: _____

Do you smoke? yes no

Do you drink alcohol? yes no
If yes, how many drinks per week? _____

Family Medical History

Have any immediate family members (parents, siblings, etc) been treated for any of the following:

Diabetes yes no

Hypertension yes no

High cholesterol yes no

Heart disease yes no

Stroke yes no

Cancer yes no

Other (list) _____

Eating Patterns

How many meals a day do you eat? _____

Do you skip meals? _____ If yes, which ones do you skip and why?

How often do you snack? Once daily Twice daily Three times daily

When do you usually snack? _____

What foods do you snack on most frequently? _____

How many meals per week do you eat at a restaurant? _____

Which restaurants do you normally choose?

How many meals per week do you eat at fast-food restaurants? _____

How does your meal and snack pattern vary on the weekend vs. during the week?

What are your favorite foods? _____

List any foods you avoid eating: _____

Do you have a list of "safe" foods? yes no

If yes, what are they? _____

Do you eat standing up? yes no

Do you eat in the car? yes no

Do you eat at the table? yes no

Do you eat with others? yes no

Do you engage in other activities when you eat? yes no

Do you feel you eat fast? yes no

Who usually prepares the food at home? _____

Do you cook? yes no

Who usually does the grocery shopping? _____

Do you read food/nutrition labels? yes no

What do you look for on labels? _____

Do you travel and/or entertain for business? yes no

How often? _____

Eating and Emotion

Do you, or have you ever, used food for comfort or to address other emotions?

yes no

If yes, please elaborate: _____

On a scale of 1-10, 10 being the highest, how much support do you need when making lifestyle changes? _____

Do you have a strong support system? _____

Exercise and Activity

Have you ever followed a consistent exercise program? yes no

Do you currently follow a consistent exercise program? yes no

If yes, please describe: _____

Do you like to exercise? yes no

What physical activity do you dislike? _____

Do you feel that your life/schedule often conflicts with a healthy exercise program?

yes no If yes, how? _____

When you feel overwhelmed or life gets busy, do you neglect your exercise routine?

yes no

Do you have fitness goals (i.e. run a 5K, etc) you've previously considered, but felt unprepared to work toward? yes no

If yes, please describe: _____

Have you ever worked with a personal trainer before? yes no

If yes, what was your experience like? _____
