NUTRITION QUESTIONNAIRE

Patient Printed Name ________________________________________________

Please answer the following questions and bring to your first appointment with the dietitian.

GENERAL INFORMATION

☐ Undergraduate  ☐ Graduate  What are you studying? ____________________________

Family History:  ☐ Diabetes  ☐ High Cholesterol  ☐ PCOS  ☐ Thyroid Issues
☐ Gluten Intolerance  ☐ Other ____________________________

Have you ever seen a dietitian before?  ☐ Yes  ☐ No  If yes, when? ____________________________

What questions do you have for the dietitian? ____________________________

Do you currently take any vitamins or supplements?  ☐ Yes  ☐ No
If yes, please list: ____________________________________________________________

Where do you live?  ☐ Residence halls  ☐ Off campus - alone  ☐ Off campus – with roommates
☐ Off campus – with family/spouse

Are you on a plan with dining services?  ☐ Yes  ☐ No
If yes, at what location(s) do you frequently dine? ____________________________

PHYSICAL ACTIVITY

Do you currently exercise?  ☐ Yes  ☐ No

What do you do for aerobic activity (e.g., walking, running, biking, exercise class)? ____________________________

How frequently do you exercise aerobically? _______ days/week for _______ minutes/day

How frequently do you strength train (e.g., weight lifting, machines, yoga)? _______ days/week
for _______ minutes/day

What do you do for leisure activities? ____________________________

Do you have any exercise limitations?  ☐ Yes  ☐ No
If yes, please describe: ________________________________________________________

DIETARY HABITS

How would you rate your diet?  ☐ Excellent  ☐ Good  ☐ Fair  ☐ Poor

(Continue on next page)
DIETARY HABITS, continued

Has your appetite changed within the past month? □Yes  □No
If yes, please explain: ____________________________________________

Do you have any food allergies or food intolerances? □Yes  □No If yes, please list: ____________________________

Have you ever been on a diet? □Yes  □No
If yes, what diets have you tried? _______________________________________

Are you currently following a special diet (e.g., low fat, low salt)? □Yes  □No
If yes, what diet are you on? _______________________________________

Have you ever purposefully restricted food intake and attained what you or others felt was an extremely low or unhealthy weight? □Yes  □No
If yes, please explain: ____________________________________________

Have you ever vomited, used laxatives, fasted or exercised for long periods of time to lose weight? □Yes  □No If yes, please explain: __________________________________________

Do you consume an excessive amount of calories in a 2 hour period, to the point of being painfully full and have negative emotions about it? □Yes  □No
If yes, please explain: ____________________________________________

Who prepares your meals? _______________________________________

Where do you eat your meals? _______________________________________

With whom do you eat your meals? _______________________________________

Out of 7 days in a week, how many days do you skip breakfast? __________________________

How often do you drink soda? □1 or less/week □2-4/week □5-10/week □11+/week

How often do you drink other sweetened beverages (e.g., sweet tea, sugary coffee drinks)? □1 or less/week □2-4/week □5-10/week □11+/week

What is your daily water intake (cups)? □1 or less/day □2-4/day □5-8/day □9+/day

How often do you eat fast food or go to a restaurant? □0-1/month □2-3/month □1-2/week □3-4/week □5+/week


When you drink, on average, how many servings of alcohol do you drink in one sitting (1 serving = 12 oz beer, 5 oz wine, 1 oz liquor)? ____________ serving(s)

Thank you for completing this questionnaire.

Dietitian Comments ____________________________________________

Dietitian Signature ____________________________________________ Date ____________

Revised 3/2018

NUTRITION QUESTIONNAIRE  Page 2 of 2