



# Nutrition and Health History Form

All information will be kept strictly confidential.

## PERSONAL INFORMATION:

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_  
Last first day/month/year

Address: \_\_\_\_\_  
street apt # city postal code

Telephone (home): \_\_\_\_\_ (work): \_\_\_\_\_

e-mail address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_

Work Schedule: \_\_\_\_\_

## MEDICAL HISTORY:

Are you presently taking any pills, drugs or medications? \_\_\_\_\_  
\_\_\_\_\_

Have you taken prolonged medications in the past? \_\_\_\_\_

Do you have, or have you had, any of the following? (check all that apply)

<input type="checkbox"/> Heart disorder	<input type="checkbox"/> High blood cholesterol		
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High triglycerides		
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood sugars	<input type="checkbox"/> Low blood sugars
<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Hepatitis/jaundice	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Cancer	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Stroke
<input type="checkbox"/> Other (please specify) _____			

Have you had surgery? (if so, what type and when?) \_\_\_\_\_  
\_\_\_\_\_

Allergy to food (if so, what?) \_\_\_\_\_  
\_\_\_\_\_

Family Medical History (Diabetes/Heart Disease etc.): \_\_\_\_\_  
\_\_\_\_\_

Are you taking any vitamin / mineral / herbal supplements? Yes No  
If yes, what? \_\_\_\_\_

Do you use any other health services? Yes No  
If yes, what? \_\_\_\_\_

**DIET HISTORY:**

What is the reason for your visit?  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever visited a registered dietitian or nutritionist? Yes/No  
What was done at the time? \_\_\_\_\_  
\_\_\_\_\_

Have you ever been on a special diet before? \_\_\_\_\_  
If so, what type of diet? \_\_\_\_\_ For how long? \_\_\_\_\_  
Pros/Cons? \_\_\_\_\_

Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

**ANTHROPOMETRICS:**

Age: \_\_\_\_\_

Height: \_\_\_\_\_

Current Wt: \_\_\_\_\_

Usual Wt: \_\_\_\_\_

Goal Weight: \_\_\_\_\_

**NUTRITION ASSESSMENT INTERVIEW:**

On a scale of 1-10 how would you rate your current nutrition?

What are the major barriers that prevent you from eating at your best?

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How often do you eat in a day (including snacks)?

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Do you skip meals? If so, when? \_\_\_\_\_

Do you eat breakfast? \_\_\_\_\_

If so, what do you typically eat? \_\_\_\_\_

Do you eat late at night? \_\_\_\_\_

What activities do you engage in while eating? (TV, Computer, Reading)

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If you had to estimate, how many calories do you consume in a given day? \_\_\_\_\_

**LIFESTYLE HABITS:**

Do you drink coffee? Yes No If yes, how many cups / day? \_\_\_\_\_

Do you drink tea? Yes No If yes, how many cups / day? \_\_\_\_\_

Do you drink milk? Yes No If yes, how many cups / day? \_\_\_\_\_

Do you drink water Yes No If yes, how many cups / day? \_\_\_\_\_

Which foods do you particularly like? \_\_\_\_\_

Which foods do you particularly dislike? \_\_\_\_\_

Which foods do you avoid for religious / ethical / cultural reasons? \_\_\_\_\_

How much alcohol do you drink / week? What is your drink of choice?  
\_\_\_\_\_  
\_\_\_\_\_

Do you smoke? Yes No \_\_\_\_\_ If yes, how much? \_\_\_\_\_

What physical activity do you do? \_\_\_\_\_

How often do you exercise? \_\_\_\_\_

At work/school do you usually EAT OUT or BRING FOOD?

How many times/week do you eat out? \_\_\_\_\_

Where do you normally eat? \_\_\_\_\_

Different Cuisines? \_\_\_\_\_

What do you typically order?  
\_\_\_\_\_

Do you do your own grocery shopping? Yes/No

Where do you shop? (circle)  
-costco – safeway – save-on-foods – independent produce store – other  
\_\_\_\_\_

Do you do your own cooking? \_\_\_\_\_

If not, who cooks the majority of food? \_\_\_\_\_

Do you cook for anyone else? \_\_\_\_\_

How do you prepare your food? (circle)

Bake – Broil – BBQ – Microwave – Pan-Fry – Deep-Fry – Steam – Grill –  
Sautee

What do you cook with? (circle)

- butter – margarine (specify)
  - salt – pepper – herbs/spices
  - oils (specify)
  - other sauces
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What type of sauces/condiments/sides do you use regularly?

- ketchup – mayo (specify)
- mustard – hot-sauce – teriyaki/sweet chili
- sour cream – hummus – tzatziki
- salad dressings
- cheese

What is your preference SWEET/SAVOURY/BOTH

Do you think that you over consume sugar? YES/NO

If yes, what are the sweets that you have a hard time saying no to?

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Are you brand loyal? YES/NO

If so, which brands do you normally buy?

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Besides hunger, what other reason(s) do you eat? (circle)

- boredom – social – stressed – tired – depressed – happy
- nervous – because you see someone else eating

Do you eat past the point of fullness? OFTEN/SOMETIMES/NEVER

Do you eat foods that are high in fat and sugar?

OFTEN/SOMETIMES/NEVER

When do you feel your energy levels drop during a 24hr period?

\_\_\_\_\_ am \_\_\_\_\_ pm

Are there any foods that you can't live without?

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What do you like about your current eating pattern?

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What are some areas that you would like to change?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

What is most important to you?

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On a scale of 1-5 how ready are you to make the necessary changes?

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How do you prefer to receive information?  
(e-mail/print/discussions/pictures etc.)

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Would you prefer something more flexible or structured?

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Primary GOALS: (in order of importance to you)

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Is there anything else I should know about your current eating patterns?

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