

Food History Questionnaire and Assessment

Name _____ Date _____

Occupation _____

Height _____ Weight _____ Age _____ Sex: _____

Desired Weight _____ Last time you weighed desired weight _____

Have you tried to lose weight before? () YES () NO
If yes, When _____

Diet (specify) _____ Weight Change _____ How long did it last? _____

Diet (specify) _____ Weight Change _____ How long did it last? _____

Weight History:

Childhood _____

Teenage _____

20's _____

30's _____

40's _____

50's _____

Have you ever used laxatives for weight control? () YES () NO

Have you ever purged for weight control? () YES () NO

Medical History (chronic illnesses, surgeries, hospitalizations)

Laboratory Values

Current Medications

Have you ever been advised by your physician to follow any type of diet? (no salt, low cholesterol, no sugar, etc) _____

What changes did you make at that time? _____

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The following are questions about your typical eating pattern:

How many days per week do you eat? (Breakfast)_____ (Lunch)_____ (Dinner)_____

How often do you snack? () once daily () twice daily () three or more times daily

When do you usually snack?_____

Do you eat out? () Yes () No How often?_____

Type of restaurants?_____

Do you eat standing up? () Yes () No () Occasionally

Do you eat at the table? () Yes () No () Occasionally

Do you eat with others? () Yes () No () Occasionally

Do you eat in the car? () Yes () No () Occasionally

Do you set the table? () Yes () No () Occasionally

Do you engage in other activities when you eat? () Yes () No

If yes, what activities?_____

Do you feel you eat fast? () Yes () No

Do you hold a conversation when you eat? () Yes () No

Who usually prepares the food at home?_____

Do you cook? () Yes () No

Do you exercise? () Yes () No

Type/duration_____

Do you drink alcohol? () Yes () No

Number of drinks per week_____

Who usually does the grocery shopping?_____

Do you read labels? () Yes () No

What do you look for on labels?_____

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Is there any member of your household on a special diet? () Yes () No

If yes, what special diet? _____

List family members, ages, their weight status and pertinent medical history _____

Do you take any vitamin, mineral or food supplement? () Yes () No

Type _____

Do you have any food allergies? () Yes () No

Specify: _____

Are your menstrual periods regular? () Yes () No () NA

What are your favorite foods? _____

Would you like to change your eating habits? () Yes () No

If yes, please explain why? _____

What are your goals for the initial nutrition consultation? _____

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Food Frequency

Check the Frequency The Following Are Consumed	Never or less than 1 time per week	1-2 times per week	3-7 times per week	More than once a day
Lean beef				
High fat beef				
Sausage, bacon				
Lunchmeat-turkey, chicken				
Pork				
Poultry				
Poultry-prebreaded (nuggets)				
Poultry-fried				
Fish				
Fish-prebreaded (nuggets)				
Fish -fried				
Shellfish				
Beans, lentils, legumes				
Peanut butter				
Pizza				
Milk (type)				
Cream				
Cheese				
Cheese-Regular				
Cheese-Low Fat				
Cheese Non-fat				
Yogurt				
Ice cream				
Frozen Yogurt				
Eggs				
Oils				
Butter				
Margarine				
Vegetables				
Fruits				
Substitute foods (Soy products, Boca burgers)				

**Please Follow Instructions Carefully In
Completing This Three-Day Record**

1. Write down everything you eat and drink and all vitamin and mineral supplements and medication taken for three (3) days.
2. Measure and record the amount of food served in portion sizes of level measuring cups, teaspoons, tablespoons, ounces. Include slices or inches. You may use a food scale if you have one.
3. Indicate how the food was prepared such as fried, steamed, baked, raw, etc.
4. List brand names of all food products, for example oatmeal might be “Quick Quaker Oats”
5. Be sure to measure and record all those little extras....gravies, salad dressings, taco sauce, pickles, jelly, sugar, ketchup, margarine etc. Indicate the amounts.
6. Try to include at least one weekend day if possible.

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Date _____

Amount	Breakfast	Time
	Snack	
	Lunch	
	Snack	
	Dinner	
	Snack	

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Date _____

Amount	Breakfast	Time
	Snack	
	Lunch	
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