

# Dietitian History Questionnaire and Assessment

**General Information:**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Occupation: \_\_\_\_\_  Full time  Part time

Place of Employment: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone #2: \_\_\_\_\_ Email: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Reason for Appointment: \_\_\_\_\_

\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Address/Phone: \_\_\_\_\_

Therapist: \_\_\_\_\_

Address/Phone: \_\_\_\_\_

Education level:  Grammar School  High School  College  Graduate School

Marital Status:  Single  Married  Divorced  Separated  Widowed

Number of Children: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

**Medical History:**

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

***Please indicate whether you or a family member have/had any of the following conditions:***

<b>Disease/Condition</b>	<b>Self</b>	<b>Family</b>	<b>Relationship</b>	<b>Treatment</b>
Asthma	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Cardiovascular Disease	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Drug Dependency	_____	_____	_____	_____
Eating Disorder	_____	_____	_____	_____
Food Allergies	_____	_____	_____	_____
Food Intolerances	_____	_____	_____	_____

Kidney Disease \_\_\_\_\_  
 Headaches \_\_\_\_\_  
 Heart Attack \_\_\_\_\_  
 High Cholesterol \_\_\_\_\_  
 Hypertension \_\_\_\_\_  
 Intestinal Problems \_\_\_\_\_  
 Menstrual Problems \_\_\_\_\_  
 Mental Health Issues \_\_\_\_\_  
 Obesity \_\_\_\_\_  
 Osteoporosis \_\_\_\_\_  
 Other \_\_\_\_\_

Are you currently being treated for any medical conditions?  Yes  No

If yes, please specify: \_\_\_\_\_

List any medications you are currently taking or have taken in the last year:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

Are you currently taking any food or nutritional/herbal supplements?  Yes  No

If yes, please specify: \_\_\_\_\_

Have you ever been advised by your physician to follow a special diet?  Yes  No

If yes, please specify: \_\_\_\_\_

Are you currently following that diet?  Yes  No

If not, why? If yes, what changes have you made? \_\_\_\_\_

Do you drink alcohol?  Yes  No Number of drinks per week: \_\_\_\_\_

Do you smoke cigarettes?  Yes  No Amount per day: \_\_\_\_\_

How long have you smoked? \_\_\_\_\_ If you quit smoking, when? \_\_\_\_\_

Do you use drugs?  Yes  No Explain: \_\_\_\_\_

**Menstrual History:** (Female Patient):

Are you currently menstruating?  Yes  No  Have never menstruated

At what age did you get your first period? \_\_\_\_\_

Date of last menstrual cycle: \_\_\_\_\_ Weight at that time: \_\_\_\_\_ pounds

Are your periods regular?  Yes  No

Are you taking birth control pills / estrogen pills?  Yes  No

Do you experience PMS?  Yes  No

If yes, what are your symptoms? \_\_\_\_\_

**Weight/Dieting History:**

Have you tried to lose weight before? \_\_\_ Yes \_\_\_ No

How many times? \_\_\_\_\_ Age of first attempt: \_\_\_ years

What did you do? \_\_\_\_\_

Why did you go on that diet? \_\_\_\_\_

Have you ever used any of the following for weight control? If yes, please explain.

Commercial diet programs \_\_\_ Yes \_\_\_ No \_\_\_\_\_

Liquid diets \_\_\_ Yes \_\_\_ No \_\_\_\_\_

Fad diets \_\_\_ Yes \_\_\_ No \_\_\_\_\_

Prescription diet pills \_\_\_ Yes \_\_\_ No \_\_\_\_\_

Over-the-counter diet pills \_\_\_ Yes \_\_\_ No \_\_\_\_\_

Laxatives \_\_\_ Yes \_\_\_ No \_\_\_\_\_

Diuretics \_\_\_ Yes \_\_\_ No \_\_\_\_\_

Ipecac syrup \_\_\_ Yes \_\_\_ No \_\_\_\_\_

Vomiting \_\_\_ Yes \_\_\_ No \_\_\_\_\_

Self-designed program \_\_\_ Yes \_\_\_ No \_\_\_\_\_

Other \_\_\_\_\_

Do you experience periods during which you eat uncontrollably? \_\_\_ Yes \_\_\_ No

If yes, how often? \_\_\_\_\_

At what age did this begin? \_\_\_\_\_ years

Is this followed by:

\_\_\_ Vomiting Age began: \_\_\_\_\_ How often? \_\_\_\_\_

\_\_\_ Laxative use Age began: \_\_\_\_\_ How often? \_\_\_\_\_

\_\_\_ Excessive exercising Age began: \_\_\_\_\_ How often? \_\_\_\_\_

\_\_\_ Self harm Age began: \_\_\_\_\_ How often? \_\_\_\_\_

\_\_\_ Negative emotions Age began: \_\_\_\_\_ How often? \_\_\_\_\_

\_\_\_ Other (explain) \_\_\_\_\_

Have you ever been diagnosed with an eating disorder? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

Are you currently or have you ever received treatment? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

Do you currently exercise for weight control? \_\_\_ Yes \_\_\_ No

Please explain: \_\_\_\_\_

**Exercise History:**

Do you exercise? \_\_\_ Yes \_\_\_ No

Please explain: \_\_\_\_\_

Do you have any physical conditions that limit your ability to exercise? \_\_\_ Yes \_\_\_ No

Please specify: \_\_\_\_\_

**Family Weight History:**

Are any members of your family overweight? \_\_\_ Yes \_\_\_ No

Please explain: \_\_\_\_\_

Are any members of your family underweight? \_\_\_ Yes \_\_\_ No

Please explain: \_\_\_\_\_

Does anyone in your family diet?  Yes  No

Please explain: \_\_\_\_\_

Did/Does anyone in your family have an eating disorder?  Yes  No

Please explain: \_\_\_\_\_

Does your family eat meals together?  Yes  No

What meals? \_\_\_\_\_

What is this like? \_\_\_\_\_

**Eating Habits:**

Do you skip meals?  Yes  No

How many days per week do you eat:

Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_ Dinner: \_\_\_\_\_

Do you snack?  Yes  No

If so, when? \_\_\_\_\_

Do you buy or pack your lunches?

Buy # days per week: \_\_\_\_\_  Pack # days per week: \_\_\_\_\_

Do you eat out?  Yes  No

How many meals per week? \_\_\_\_\_

What restaurants do you usually choose?

1. \_\_\_\_\_ 4. \_\_\_\_\_ 7. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_

Who usually prepares the food at home? \_\_\_\_\_

Do you know how to cook?  Yes  No

Who does the grocery shopping? \_\_\_\_\_

Do you read food labels?  Yes  No What do you look at on the label? \_\_\_\_\_

Do the nutrition facts influence your decision to eat the food?  Yes  No

Do you eat standing up?  Yes  No

Do you eat in the car?  Yes  No

Do you eat while watching TV?  Yes  No

Do you eat while reading or on the computer?  Yes  No

Do you eat with others?  Yes  No

Do you eat fast?  Yes  No

Do you eat when bored?  Yes  No

Do you eat when stressed?  Yes  No

Do you eat when you are anxious?  Yes  No

Do you eat when you are lonely?  Yes  No

Do you eat when you are hungry?  Yes  No

Do you eat when you are not hungry?  Yes  No

Do you avoid certain foods?  Yes  No

If yes, please specify: \_\_\_\_\_

What are your favorite foods? \_\_\_\_\_

**Malnutrition Symptoms:**

Do you now or have you ever experienced (for each checked, please add details to explain):

- Irregular menstrual periods \_\_\_\_\_
- Absent menstrual periods \_\_\_\_\_
- Cold intolerance \_\_\_\_\_
- Tingling sensation in hands or feet \_\_\_\_\_
- Headaches \_\_\_\_\_
- Lightheadedness/Dizziness \_\_\_\_\_
- Fainting \_\_\_\_\_
- Sleeping difficulties \_\_\_\_\_
- Skin changes \_\_\_\_\_
- Hair loss \_\_\_\_\_
- Hair growth on face and/or chest \_\_\_\_\_
- Chest pains \_\_\_\_\_
- Rapid heart beat \_\_\_\_\_
- Shortness of breath \_\_\_\_\_
- Mood swings \_\_\_\_\_
- Episodes of crying for "no reason" \_\_\_\_\_
- Frequently thinking about food \_\_\_\_\_
- Confusion \_\_\_\_\_
- Difficulty concentrating \_\_\_\_\_
- Anxiety, especially around food \_\_\_\_\_
- Less social interaction with family \_\_\_\_\_
- Frequently tired \_\_\_\_\_
- Memory problems \_\_\_\_\_
- Difficulty making decisions \_\_\_\_\_
- Problems with teeth \_\_\_\_\_
- Sore throat \_\_\_\_\_
- Swollen parotid glands \_\_\_\_\_
- Taste changes \_\_\_\_\_
- Constipation \_\_\_\_\_
- Diarrhea \_\_\_\_\_
- Muscle pain \_\_\_\_\_
- Joint pain \_\_\_\_\_
- Obsessive-compulsive behaviors \_\_\_\_\_
- Feelings of depression \_\_\_\_\_
- Other (explain) \_\_\_\_\_

**Goals/Expectations**

Do you want to change your eating habits?  Yes  No  
Why? \_\_\_\_\_

Did you have any expectations from coming to see the nutritionist today?  Yes  No  
Please explain: \_\_\_\_\_



