

Nutrition and Eating Habits Questionnaire

NAME

BIRTHDATE

Thank you for taking time to complete this questionnaire

1. What would you like to learn about or gain from this appointment?
improve blood glucose improve eating habits weight loss
eating out label reading exercise
lower cholesterol lower salt/sodium fiber
alcohol use meal planning what to eat
carbohydrate counting how much to eat sugar substitutes
other

2. How would you describe your appetite? Good fair poor

3. Do you have any eating or digestion problems such as
Chewing diarrhea gas swallowing indigestion constipation
other

4. Do you drink alcoholic beverages? Beer wine liquor
If yes, how often? how much?

5. Do you take vitamin or herbal supplements? Yes No
If yes, please list the names and amounts you take

6. Do you use any meal replacement products such as: (Ensure, Boost, Glucerna)
Yes No
If yes, which ones and how often?

7. Who does the cooking and food shopping in your home? Self other

8. What time do you eat?
Breakfast Lunch Dinner Snacks

9. Do these times change on weekends? Yes No

10. How many meals do you eat away from home on weekdays?
Breakfast Lunch Dinner

11. How many meals do you eat away from home on the weekends?

	Breakfast	Lunch	Dinner			
12.	.Have you had diet counseling before?			Yes	No	
13.	Do you have a meal plan?		Yes	No		
	If yes, how many calories?					
14.	What food planning method do you use?			None	Carbohydrate Counting	
	Calorie Counting	Exchange Lists		Healthy Eating Using the Food Pyramid		
15.	How much of the time are you able to follow it?					
	0%-25%	25%-50%	50%-75%	75%-100%		
16.	Have you been told to follow any other diet restrictions?				Yes	No
	If yes, what are they?					
	low calorie	low cholesterol	low salt/sodium	low protein		
	low fat	high fiber	Other			
17.	Has your weight changed in the past year?			No	Gained	Lost
18.	What would you like to weigh?					
19.	Do you exercise now?		Yes	No		
	If yes, what type of exercise do you do?					
	How often do you exercise and for how long?					
	If no, what exercise would you consider?					
20.	Is there any reason you should not exercise?				Yes	No
	If yes, please describe					
21.	If recommended, would it be hard for you to make changes in your eating habits?					
	Yes		No			
	If yes, why?					
22.	What are your usual working hours? _____					

