UNIVERSITY OF DELAWARE HEALTH

Patient Name: _____

Date of Birth: _____**Age:**_____

Today's Date: _____

Food and Health History Questionnaire

1. **I'm interested in seeing a Registered Dietitian Nutritionist because….**

_____

_____

_____

_____

2. **Past Medical History** (*please check-off all that applies to you):*

_____ NO Past Medical History

Cardiovascular
__Heart Attack/Angina
__High Blood Pressure
__Arrhythmia/Palpitation
__Heart Failure/CHF
__Heart Surgery
__Stents/Angioplasty
__Peripheral Vascular Disease

GI
__Ulcer/Gastritis
__Acid Reflux/GERD
__Inflammatory Bowel Disease (Colitis/Crohn's)
__Celiac Disease
__Diarrhea
__Constipation
__Nausea/Vomiting
__Irritable Bowel Syndrome
__Diverticular Disease

Musculoskeletal
__Lupus/SLE
__Fibromyalgia
__Arthritis
__Osteoporosis

Respiratory
__Asthma
__COPD
__Obstructive Sleep Apnea
__Smoker: Y N Former
Packs Per Day:____
For how many years?:_____

Endocrine
__Diabetes
__Thyroid disorder
__Menstrual Disorder
__Hypoglycemia (low blood sugar)

Hematologic
__Anemia
__Blood Clots
__Sickle Cell Disease
__Lyme Disease
__MRSA
__HIV/AIDS
__Hepatitis: A B C

Neurological
__Stroke/TIA
__Seizures
__Neuropathy
__Concussion

Oncology
__Cancer
Type: _____
Treatment:
_____

Mental Health
__Anxiety
__Depression
__Bipolar
__Schizophrenia
__Dementia
__ADD/ADHD
__Eating Disorder

Other Medical or Surgical History: _____

_____

If you have had bariatric surgery please list date and type of procedure_____

_____

Family History (*please check off if you have had any blood relatives with any of the following):*

__Alzheimer's Disease __Dementia_ __Heart disease __High cholesterol __Osteoporosis
__Cancer __Diabetes/Prediabetes __High blood pressure __Kidney disease __Stroke
__Other:_____

3. **Lifestyle**

How any days per week do you exercise? _____ days **For how many minutes per day?** _____

Please describe the type of activity (e.g., walking, jogging, biking, etc.):

_____

Which of the following best describes your current activity level?

__Little to no exercise in a day __Light exercise 1-3days/week __Moderate exercise 3-5 days/week __Hard exercise 6-7 days/week

Do you have any physical limitations or other reasons that make it difficult for you to exercise?

_____

Please rate your stress level from 0 to 10: _____ **Hours of sleep on weeknights?**_____ **Weekends?**_____

Do you smoke? __No __Yes **If yes, packs/day**:_____ **Do you drink alcohol**? __No __Yes **If yes, drinks/week**: _____

4. Social History

Birth sex: __Female __Male __Undifferentiated __Choose Not to Report

Gender identity:
__Female __Male __Choose Not to Report
__Female-to-Male/Transgender Male __Male-to-Female/Transgender Female __Other Gender Category:_____

Racial background:
__Black or African American __American Indian/Alaskan Native __Choose Not to Report
__White __Native Hawaiian/Other Pacific Islander __Other:_____
__Asian __Unknown

Ethnicity: __Hispanic/Latino __Not Hispanic/Latino __Other __Choose Not to Report

Marital status: __Single __Married __Choose Not to Report

Do you have children? __No __Yes __If yes, how many? _____

Employment: __Employed __Unemployed __Retired __Student __Choose Not to Report

Occupation:_____

Do you travel often for work? __No __Yes __If yes, how often? _____

Food Security (HVS):
Within the past 12 months, I worried about whether my food would run out before I got money to buy more?
__Often True (1) __Sometimes True (1) __Rarely True (0) __Never True (0) __Choose Not to Report

Within the past 12 months, the food I bought didn't last and I didn't have money to buy more?
__Often True (1) __Sometimes True (1) __Rarely True (0) __Never True (0) __Choose Not to Report

Are you enrolled in any of these programs? __EBT/Food Stamps/SNAP __Meals on Wheels __WIC __Other_____

5. Medication: *Please list ALL medications you currently take or attach a list of medications.*

Medication,	Dosage Amount	Frequency	Last Dose: Date and Time

6. Weight History
Height (feet and inches) _____ft _____ in **Estimated current weight** (lbs)_____

Usual body weight (lbs)_____ **Lowest adult weight** (lbs)_____ **Highest weight** (lbs)_____ **Desired Weight** (lbs)_____

Have you recently lost weight? (MST)
__No (0) __Yes (1) __Unsure (1) **If yes, was it**: __intentional or __unintentional?

If yes, how many pounds (lbs)? __0 lbs (0) __2-13 lbs (1) __14-23 lbs (2) __24-33 lbs (3) __34 lbs+ (4) __unsure (2)

If yes, what was the time frame for the weight loss? __week(s) __month(s) __year(s) __other_____

Have you recently gained weight?
__No __Yes __Unsure **If yes, was it**: __intentional or __unintentional?

If yes, how many pounds (lbs)? __0 lbs __2-13 lbs __14-23 lbs __24-33 lbs __34 lbs+ __unsure

If yes, what was the time frame for the weight gain? __week(s) __month(s) __year(s) __other_____

7. **Laboratory Results:** Date of last blood work (MM/YEAR): _____ Please attach a copy of results.

8. **Food and Nutrition:**
How is your appetite? __Poor __Fair __Adequate __Excessive

Have you been eating poorly because of a decreased appetite? (MST) __No (0) __Yes (1)

Do you have problems chewing? __No __Yes __If yes, please explain:_____

Do you have problems swallowing? __No __Yes __If yes, please explain:_____

Gastrointestinal complaints: __None __Nausea __Vomiting __Constipation __Diarrhea
__Gas __Bloating __Acid reflux/GERD __Other_____

What do you consider to be the biggest issue/challenge with your diet (e.g. limited access to healthy food, busy lifestyle, stress, significant cravings for sweets, etc.)?

_____

_____

Which meals do you usually eat every day? __Breakfast (time:_____) __Lunch (time:_____) __Dinner (time:_____)

Which snacks do you usually eat every day? __Morning (time:_____) __Afternoon (time:_____) __Evening (time:_____)

Has a doctor recommended you follow specific eating plan/diet? __No __Yes

If yes, specify_____**Do you currently follow this eating plan?** __No __Yes

Are you a: __Vegetarian __Vegan __Lacto-ovo Vegetarian (Dairy & eggs) __Flexitarian
__Pescatarian (Fish only) __Lacto-Vegetarian (Dairy only) __Ovo-Vegetarian (Eggs only)

Other than the above, do you follow a specific diet that excludes specific foods or food groups? __No __Yes

If yes, specify_____

Do you have any of the following food allergies?
__None __Fish __Shellfish __Tree nuts __Other:_____
__Egg __Milk __Soy __Wheat __Other:_____

List any foods that you do not tolerate well or that don't agree with you:

_____

_____

Please list any other foods or food groups that you usually avoid eating:

_____

_____

Food and Health History Questionnaire *Patient Name*_____*DOB*_____

Please list any specific dietary preferences or restrictions based on your religion or cultural background:

Preferences_____

_____

Restrictions_____

_____

Do you have a sweet tooth or crave salty foods?_____

_____

Do you drink coffee? __No__Yes If Yes,how many cups/day?_____ Milk/Creamer? __No _Yes Added Sugar? __No __Yes

Do you drink tea? __No__Yes If Yes, how many cups/day?_____ Milk/Creamer? __No _Yes Added Sugar? __No __Yes

Do you drink: __Energy Drinks __Diet soda/drinks/iced tea __Fruit juice/Juice drinks __Regular soda/iced tea

Do you drink: __Whole milk __2% milk __1% milk __Skim (fat-free) milk __Alcohol
__Soy milk _Almond milk __Oat milk __Other:_____ __# Alcohol drinks/week

Each day, how many servings of the following do you have?
Water:_____cups/day Dairy_____servings/day Fruit_____servings/day Vegetables_____servings/day

Do you cook at home? __No __Yes Who does the cooking? __Self __Spouse/Partner __Shared

Do you eat out often? __No __Yes How many times per week? _____

Type of food/restaurant? __Fast Food __Casual __Fine _Sandwich/Sub __Pizza __Sushi _Other:_____

How many times/week do you eat out for: Breakfast_____times/week Lunch_____times/week Dinner_____times/week

What triggers you to eat? __Boredom __Emotions __Hunger _Seeing/Smelling Food _Time of day

TYPICAL FOOD INTAKE: Please write down everything you ate and drank over the past 24 hours if you did not complete the requested food journal.

Breakfast: Time: _____	
Snack: Time: _____	
Lunch: Time: _____	
Snack: Time: _____	
Dinner: Time: _____	
Snack: Time: _____	

What eating changes/health improvements would you like to make?
__None __Improve my eating habits __Improve my blood sugar _Improve my cholesterol levels __Learn to manage my weight

__Other_____

What information would you like from your Dietitian?

__None __Eating less fat __Eating out __Fiber __Food labels __Healthy food preparation __Healthy snacks
__Meal planning tips __Personalized Meal Plan __Portion sizes __Weight management

Other nutrition concerns: *Please list any specific nutrition goals or concerns you would like to discuss at today's visit:*

_____

_____

_____

_____

_____

Please list any supplements/vitamins that you take:

Vitamin/Supplement	Dose	Brand Name

Thank you for completing the Food and Health History Questionnaire, we look forward to seeing you in the UD Health Nutrition Clinic soon!

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