Gwinnett Hospital System

PLACE LABEL HERE

NUTRITION QUESTIONNAIRE and AMBULATORY SUMMARY

Please complete this form to help your Dietitian learn about you.

ABOUT YOURSELF

Name:_____ Date:_____

Education/Last grade attended: _____ Occupation: _____

Work hours:_____ Primary language: _____ Do you speak/read English? ❑ Yes ❑ No

How do you learn best? ❑ written materials ❑ listening/discussion ❑ video ❑ demonstration

LIFESTYLE

Do you routinely exercise? ❑ Yes ❑ No What type and how often? _____

Do you smoke? ❑ Yes ❑ No If yes, how much? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how many drinks a week?_____

Do you feel you are overweight? ❑ Yes ❑ No What is a realistic weight for you? _____

If you are overweight, what do you feel is the reason? (check all that apply) ❑ Frequent over-eating
❑ Enjoy fattening food ❑ Insufficient activity ❑ Other: _____

List any cultural/religious practices that need to be included in managing your condition?_____

_____

NUTRITION

How would you like your dietician to help you at this appointment? _____

How many meals do you eat daily? _____ Snacks?_____

How many meals do you eat at home per week? _____ Eat out per week?_____

At what types of restaurants do you eat? _____

How much water do you drink daily? _____ How much milk? _____

Who does the food preparation in your household? _____ The shopping? _____

How many weight reduction diets have you tried?_____ (check all that apply)

❑ Do it yourself	❑ Weight Watchers	❑ Jenny Craig	❑ Other:
❑ Quick Weight Loss	❑ Atkins	❑ Physician	
❑ Nutri-System	❑ Optifast	❑ Medications	

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DIET HISTORY

Please list what you eat in a typical day; include times of meals:

Morning (Breakfast)	Mid-morning	Mid-day (Lunch)
Mid-Afternoon	**Evening (Dinner)**	**Before Bed**

List any recent changes in your eating habits: _____

_____

List any special food considerations in developing a meal plan for you: _____

_____

HEALTH

Are you under the care of a physician? ❑ Yes ❑ No If yes, Why?_____

_____

MEDICATION / DOSAGE	KNOWN ALLERGIES AND DRUG / FOOD INTERACTIONS
❑ See Home Medication List	❑ See Home Medication List

SIGNIFICANT OPERATIVE AND INVASIVE PROCEDURES	Office Use Only Initials
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

PLACE LABEL HERE

NUTRITION QUESTIONNAIRE and AMBULATORY SUMMARY

PROBLEMS / DIAGNOSES / CONDITIONS *Check all that apply and add any not listed.*	For Office Use Only		
	Date Entered	Date Resolved	Initials
1. ❑ Hyper or Hypothyroidism			
2. ❑ Unexplained Weight Loss			
3. ❑ Eating Disorder: Anorexia/Bulimia			
4. ❑ High Blood Sugar			
5. ❑ Low Blood Sugar			
6. ❑ Arthritis			
7. ❑ Osteoporosis			
8. ❑ Lactose / Milk Intolerance			
9. ❑ Diarrhea/Constipation			
10. ❑ Kidney Problems			
11. ❑ Foot Problems			
12. ❑ Vision Problems			
13. ❑ Heart Problems			
14. ❑ High Blood Pressure			
15. ❑ Circulation Problems			
16. ❑ Hearing Problems			
17. ❑ Tuberculosis			
18. ❑ Hepatitis			
19. ❑ Cancer			
20. ❑ Urinary Problems			
21. ❑ Sexual Difficulties			
22. ❑ Vaginal Infections			
23. ❑ Menstrual Problems			
24. ❑ Polycystic Ovarian Syndrome			
25. ❑ Recurring Infections			
26. ❑ Emotional Illness			
27.			
28.			
29.			
30.			

Date _____ Time _____ Signature _____ Relationship to patient _____

For Office Use Only. Reviewed by:

Date Reviewed	Time Reviewed	Name & Title	Initials