INDIANA UNIVERSITY NORTHWEST

NUTRITION HISTORY QUESTIONNAIRE

Name:_____ Employee ID#:_____ Date:_____ Age:____

Please answer the following questions.

1. **Do you have nutritional concerns?** ◯ Yes (check all that apply) ◯ No
   - ☐ healthy eating
   - ☐ weight gain
   - ☐ high cholesterol
   - ☐ sports nutrition
   - ☐ weight reduction
   - ☐ hypoglycemic
   - ☐ digestion problems
   - ☐ diabetic
   - ☐ salt intake
   - ☐ high blood pressure
   - ☐ other (describe): _____

2. **Food allergies or intolerances?** _____

_____

3. **Describe type and amount of usual physical activity and/or exercise for you:** _____

_____

_____

4. **Do you take any medications on a regular basis?** ◯ Yes (list below) ◯ No

Medication name(s) and amount: _____

_____

5. **Do you take vitamins, mineral supplements or herbs?** ◯ Yes (list below) ◯ No

Describe product, amount, and how often taken: _____

_____

6. **Rate your appetite (check one):** ◯ excellent ◯ good ◯ fair ◯ poor
7. **Have you noticed any change in your appetite for certain foods?** ◯ Yes (explain below) ◯ No

If yes, please explain: _____

8. **With whom do you usually eat your meals?** ☐ friends ☐ alone ☐ family ☐ other
9. **Where do you usually eat your meals (please check all that apply)?**
   - ☐ at work (_____ times per day)
   - ☐ at home (_____ times per day)
   - ☐ in a restaurant (_____ times per day or _____ times per week)
   - ☐ "take out" or "on the go" (_____ times per day or _____ times per week)
   - ☐ at IUN cafeteria (_____ times per week)
   - ☐ vending machines (_____ times per week)

10. Who prepares your meals? ☐ self ☐ spouse/partner ☐ restaurant ☐ other (please list)

_____

11. In each line, please mark <u>one</u> box for frequency (more than once daily, daily, a few times a week, or rarely/never) and list specific foods you usually choose from each category.

Food	Frequency				Foods or types of foods I usually eat in this category are:
	More Than Once Daily	Daily	A Few Times A Week	Rarely Or Never	
Milk, Yogurt, or Soymilk	○	○	○	○	
Cheese	○	○	○	○	
Vegetables	○	○	○	○	
Fruit	○	○	○	○	
100% Fruit Juice	○	○	○	○	
Grains/Breads/Cereal/ Noodles/Rice/Pasta	○	○	○	○	
Meat/Poultry/Fish/Beans/ Eggs/Tofu/Soy Products/ Nuts/Seeds	○	○	○	○	

12. Which beverages do you drink (check all that apply)?

☐ water ☐ sports drink ☐ coffee ☐ tea ☐ juice
☐ milk (☐ skim ☐ ½% ☐ 1% ☐ 2% ☐ whole)
☐ soda/pop (○ diet OR ○ regular)
☐ soy or rice milk (○ fortified OR ○ unfortified)
☐ alcohol (☐ beer ☐ wine ☐ liquor)
☐ other: _____

13. Food dislikes: _____

_____

14. Describe what you ate and drank, <u>yesterday</u>, below. Please use yesterday, even if it is not a typical day. Be as specific as you can when listing food names and amounts.

Meals	Specific Food Item and Approximate Amount
Woke up at _____ a.m. to start the day. Breakfast What time did you eat breakfast? _____ How many times per week do you eat this meal? _____	
Mid-Morning Snack	
Lunch What time did you eat lunch? _____ How many times per week do you eat this meal? _____	
Mid-Afternoon Snack	
Dinner What time did you eat dinner? _____ How many times per week do you eat this meal? _____	
Evening Snack Bedtime for evening at _____ p.m.	

15. Is there anything not on this form that you would like to discuss with the dietitian? _____

_____

_____

_____

_____

_____

_____