Nutrition Questionnaire

NCMC Adult Weight Management

Please answer each of the questions below to help the Registered Dietitian have a better understanding of your needs.

Date: ___/___/_____Name: _____Sex: _____ Age: _____

Medical History

1. Check the following medical conditions you have been diagnosed with:
   - o Heart disease
   - o Heart attack
   - o Cardiovascular disease
   - o Stroke
   - o High blood pressure
   - o High cholesterol
   - o High triglycerides
   - o Metabolic syndrome
   - o Asthma/Respiratory problems
   - o Sleep apnea
   - o Diabetes
   - o Thyroid condition
   - o GI disorders
   - o Gall bladder disease
   - o Renal disease
   - o Liver disease
   - o Cancer
   - o Other: _____
2. List all medications:_____
   _____
3. Vitamin, mineral, or other dietary supplements: _____
   _____
4. List all known allergies:_____
   _____

Social History

5. Do you smoke?
   - o No
   - o Yes, how many in a typical day? _____
6. Do you drink alcohol?
   - o No
   - o Yes - How many times during the week? ____How many drinks at a time? ____
7. Describe your family – number of people who live with you and their relationship to you
   Marital status: ___Married ___ Single ___ Widowed ___ Divorced ___ Separated
   - o Children: How many _____, ages _____
     Other – describe: _____

Weight history

8. Are you concerned about your weight?
   - o No (skip to question 10)

- o Yes, I want to stop gaining weight
- o Yes, I want to lose weight

9. What do you think weighing less will do for you?

   In the next few months:

   _____

   _____

   In the next two years:

   _____

   _____

10. Current weight: _____ Current height: _____ Goal weight: _____
11. Lowest adult weight: _____ Age at this weight: _____
    Highest adult weight: _____ Age at this weight: _____

Diet History

12. Are you currently on a diet or taking prescribed or over-the-counter medications to lose weight or maintain your current weight?
    - o No
    - o Yes, I am on a diet. Describe the diet.

      _____
    - o Yes, I am on these weight loss medications:

      _____
13. Have you tried to lose weight in the past?
    - o No (skip to question 15)
    - o Yes. Check all methods that you tried
      - o Diet(s) _____
      - o Medications. List. _____
      - o Other. Describe. _____
14. If yes to number 13, did you lose weight?
    - o No
    - o Yes _____ Ibs. Over this period of time: _____

      How much of this weight, if any did you gain back? _____ Ibs.

      What worked best for you and why?

      _____

      _____
15. In the past year, have you tried losing weight or control your weight by taking diet pills, laxatives, or not eating?
    - o Yes
    - o No
16. Check the types of foods you and your family eats and how many times in a typical week:
    - o Heat and serve meals _____
    - o Home-cooked meals _____

- Fast foods/ Take-out _____
- Restaurants_____

17. Check all that apply:
    - My family eats most meals together
    - Family meals are served at regular times on most days
    - My family is supportive of my efforts to lose weight
    - Another member of my family is on a special diet or is trying to lose weight. Describe. _____
18. List any food allergies:_____
    Foods you avoid for religious, personal, or cultural reasons:_____
    Foods your Doctor told you to avoid:_____

*Don't forget to fill out a 3-day food journal (including types of foods eaten, amounts, and times.)

Physical Activity

19. Do you participate in regular physical activity?
    - No. What exercise do you like to do?_____
    - Yes. What type (s)? _____
      How long? _____ How many times a week? _____
20. Check all that apply regarding your physical activity readiness:
    - I have a heart condition or other medical condition not mentioned here that might need special attention in an exercise program.
    - I am pregnant and my healthcare professional hasn't given me the OK to be physically active
    - During or right after I exercises, I often have pains or pressure in my neck, left shoulder, or arm.
    - I have developed chest pain within the last month.
    - I am currently taking medications prescribed by my Doctor for a blood pressure or heart condition.
    - I tend to lose consciousness or fall over due to dizziness.
    - I am over 50, haven't been physically active and am planning on starting on a vigorous exercise routine.

NOTE: If you checked one or more of the questions above, you will be asked to speak with your Primary Care Physician by phone or in person BEFORE you start becoming more physically active.
Reference: www.americanheart.org/start

Other

21. On a scale of 1-10 (1= not very important, 5 = somewhat important, and 10 = very important)
    a) How important is it for you to make lifestyle changes such as adjusting your diet, increasing your physical activity, and changing health-related behaviors? _____
    b) How ready are you to make lifestyle changes? _____
    c) How confident are you that you can make lifestyle changes? _____

22. What lifestyle changes would you be willing to make?

    _____
    _____

23. What things might make it hard for you to make lifestyle changes?

    _____
    _____

Nutrition Quality of life

During the last 2 weeks, I (Check all that apply):

- o Ate enough food to be satisfied
- o Had plenty of choice in the food I ate
- o Was hungry between meals
- o Sneaked food
- o Tasted and enjoyed foods without guilt
- o Took time to eat the food that was best for me
- o Took time to shop and prepare the food that was best for me
- o Liked the way I look
- o Liked the way my clothes fit
- o Beat myself up when I ate the food I felt I shouldn't have
- o Took time for myself
- o Was pleased with the way I managed what I ate
- o Was confused about the food I should eat
- o Rewarded myself with food
- o Was happy about the food I ate
- o Felt that food was controlling me
- o Felt that changing the food I ate would make life more enjoyable for me
- o Felt frustrated about limiting the food I ate
- o Was angry that I had to change what and how I ate
- o created stress with my family/friends over my food needs
- o Was nagged by my friends/family about the food I ate
- o Had someone I could talk to who understood the struggles I have had with food
- o Found it difficult to stick to the food I thought I should eat while with family/friends
- o Knew what type of food I should have been eating for my healthy lifestyle
- o Knew the amount of food I could eat
- o Made healthy food choices
- o Ate the recommended amount
- o Ate when I should have
- o Felt confident that I could trust myself when faced with difficult food choices
- o Felt confident that I would be able to live the rest of my life with these changes in my food

Reference: Barr J, Schumacher G. *J Amer Diet Assoc.* 2003; 103:844-851.