

Reproductive Medicine Associates of Connecticut

Carolyn Gundell, MS

NUTRITION QUESTIONNAIRE

Please bring to first nutrition appointment

Date _____

Patient Name _____ Date of Birth _____

Partner's Name _____ Date of Birth _____

Address _____
Street City State Zip

Home Tel # _____ Cell # _____ Email _____

1. Please list your ethnic background? (for purpose of determining health risk factor) _____

2. How are you hoping to benefit from this nutrition session?

3. Do you have any food allergies or other allergies? Yes / No epi-pen

Please List _____

4. Do you have any food intolerances? Gastro-intestinal conditions? Yes / No

Please Explain _____

5. Do you have cultural or religious food preferences? Yes / No

Please Explain _____

6. Are you presently following a specific diet? Yes / No Please explain

7. Please list any present medical/health concerns? Past surgeries?

8. Please list any medications that you are presently taking and reason prescribed:

9. Please list any vitamins/supplements that you are presently taking and reason prescribed:

BEVERAGES

10. Circle all beverages you drink

milk water juice soda reg /diet gatorade coffee tea decaf / caffeine

seltzer wine alcohol herbal bev Other _____

MILK

11. Do you drink milk? Yes / No Circle which kind

Cow's milk - skim 1% 2% Whole fat in cereal only

Soy milk - plain vanilla chocolate Rice bev plain flavored in coffee only

PROTEIN

12. Circle protein items that you eat

Chicken Beef Turkey Fish Tuna fish Peanut butter Beans/ legumes Tofu Eggs
Nuts Seeds Edamane Cheese

FRUIT

13. How many times do you eat fresh fruit?

Per Day -- Never 0-1 1-2 2-3 3-4 5+

Per Week -- Never 0-1 1-2 2-3 3-4 5+

VEGETABLES

14. How many times do you eat vegetables, excluding salad?

Per Day -- Never 0-1 1-2 2-3 3-4

Per Week -- Never 0-1 1-2 2-3 3-4 5+

GRAINS/ BREADS

15. Circle which item(s) you will eat

white bread whole wheat bread white rice cereal waffles pancakes brown rice
pasta bagel english muffins tortilla other _____

FATS

16. Underline what kind of fat spread you use?

Butter stick margarine tub margarine olive oil vegetable oil

How often? Each meal Only on certain foods Cooking only

LIFESTYLE

17. Do you work? Yes / no What is your occupation? _____

18. Circle Type of work - sitting / active How many days /week _____ hours/week? _____

19. How many hours of TV watching _____ per day? Video Games _____ per day?

20. Time on computers? _____ per day? Is there a television in the bedroom? Yes / No

21. What time do you go to sleep at night? _____ Wake? _____ Nap? _____

22. Do you wake rested? Yes / No Do you snore? Yes /No Are you a restless sleeper? Yes / No

23. Do you participate in regular structured activity? Yes / No What ? How often?

24. What other type of activities do you enjoy doing?

SAMPLE FOOD CHOICES

25. How often do you eat in restaurants or take out? _____ times / week _____ per month

Where do you go? _____

26. Please list all snack choices available to you at home and work

27. Please list type of food choices that you would choose for breakfast, lunch, and dinner:

BREAKFAST

Are you a breakfast
Skipper? _____
How Often? _____
On the go type? _____
How often? _____

Food Choices:

LUNCH

Do you eat lunch at your desk? _____
Are you a lunch skipper? _____

DINNER



Additional
Comments _____
