Name: _____ Age: _____

Today's Date: _____ Date of Birth: _____

Email Address: _____

Primary Physician: _____

DuPage Medical Group

WE CARE FOR YOU

NUTRITION ASSESSMENT

Health History:

Do you smoke? ☐ No ☐ Yes Did you ever smoke? ☐ No ☐ Yes When did you quit?_____

How much do/did you smoke? _____packs per day for _____number of years

Do you drink alcohol? ☐ No ☐ Yes If Yes, what type: ☐ Wine ☐Beer ☐Mixed drinks

How much? ____ drinks per day ***or*** ____ drinks per week ***or*** ____ drinks per month

Check if you have every had any of the following conditions:					
	Heart Problems		Circulation Problems		Food Allergies / Intolerances
	High Cholesterol		Breathing Problems		Celiac Disease
	High Blood Pressure		Sleep Apnea		Gestational Diabetes
	Cancer _____		Stomach Problems		PCOS
	Kidney Disease		Depression/Mental Illness		Other _____

Weight History:

Height: _____ Weight: _____ Has your weight changed in the last year? ☐ No ☐ Yes

What do you think is a realistic weight for you?_____ lbs.

What has been the history of your weight over your life?

Age 20s_____ Age 30s_____ Age 40s_____ Age 50s_____

Age 60s+_____ Add'l comments:_____

What have you tried in the past to manage your weight?

Program	Year	Result (lbs lost or gained)
☐Weight Program(s)		
☐Diet Pills		
☐Exercise		
☐Self-directed diet and exercise		

Exercise History:

Do you exercise now? ☐ No ☐ Yes - - - If yes, what do you do and how often do you do it?

I do _____ for _____minutes ____times a week for the past _____months.

I do _____ for _____minutes ____times a week for the past _____months.

Do you have any barriers to exercise? ☐ No ☐ Yes

If yes, please describe: ☐time limitations ☐physical limitations ☐ other limitations_____

Nutrition History:

Why have you decided to come for nutrition counseling at this time? _____

_____

Are you currently following a special diet? ☐ No ☐ Yes if yes, please describe: _____

_____

Do you understand how to read a food label? ☐ No ☐ Yes; Questions? _____

_____

Give a sample of your meals for a typical day ***(If you brought in a food log, give it to the dietitian & go to the next question)*:**

Time: _____ Breakfast: _____

Time: _____ Snack: _____

Time: _____ Lunch: _____

Time: _____ Snack: _____

Time: _____ Dinner: _____

Time: _____ Snack: _____

What beverages do you drink in a typical day? _____

Do you take any vitamins, minerals or other diet supplements? ☐ No ☐ Yes--if yes, what?

_____

Do you do your own food shopping? ☐No ☐Yes Do you do your own cooking? ☐No ☐Yes

How many times a week do you eat out for: Breakfast? _____ Lunch? _____ Dinner? _____

Types of places you eat out at: _____ fast food _____ café _____buffets _____take out _____fine dining

STAFF ONLY

Assessment Performed By: Date:

_____ _____

PATIENT LABEL