

Medical Nutrition Therapy Questionnaire

Name: _____ Date of Birth: _____ Date: _____
Age: _____ Sex: _____ Occupation: _____ Email address: _____

Weight History:

Height _____ Present weight _____ Usual weight _____ Desired weight _____

Medical History:

Please check any of the following that you have or have had:

Shortness of breath Chest pain Irregular heart beat
 Abnormal stress test Angioplasty Stent
 Heart attack Open heart surgery Heart failure

List any other medical problems that you have or have had in the past: _____

List any medications that you take: _____

List any vitamins or herbs that you take: _____

List any food allergies that you have: _____
Do you smoke? Yes _____ No _____

Labs: (if known; OK to put "normal" if you have not had problems before)

Blood pressure: _____ Triglycerides: _____
Total cholesterol: _____ Blood sugar: _____
HDL: _____ LDL: _____
Other: _____

Diet History:

Have you been on any type diet before? Yes _____ No _____

If yes, what type: _____
How did it work for you? _____

Exercise:

Date of last stress test: _____

What are some types of exercise/activities that you do and how often: _____

What type of exercise restrictions do you have? _____

How would you describe your current exercise level?

None _____ Light _____ Moderate _____ Strenuous _____

Stress:

How would you describe your current stress level?

Low _____ Medium _____ High _____ Extremely high _____

What are some issues that are making you have more stress lately? _____

What are some things that you do to relieve stress? _____

Usual Eating Habits:

Please write down foods that you eat in a usual day:

First Meal (time): _____

Snack: _____

Second Meal (time): _____

Snack: _____

Third Meal (time): _____

Snack: _____

Comments:

What in particular do you feel like you need help with to improve your nutrition? _____