Patient Nutrition Questionnaire

Please complete and return to: Peggy J. Wright, LDN, RD; 1800 Buckner Square, Ste A-100, Shreveport, LA 71101; (318) 227-9767; Fax:(318) 227-3520

Name: _____ Date: _____

1. How tall are you? _____ft. _____inches
2. What is your usual weight? _____ Last weighed?_____(date)
3. What weight would you like to be? _____
4. Please described your appetite: ____Good ____Fair ____Poor
   _____Stable ____Improving _____Decreasing

5. Please check or explain below, if you are having problems with any of the following:
   ____ Nausea / Vomiting_____
   ____Constipation _____
   ____Diarrhea _____
   ____Taste Changes _____
   ____Teeth/Dentures_____
   ____ Chewing/ Swallowing _____
   ____Purchasing /Cooking of Food_____
   _____
   ____Food Allergies_____
   ____Unusual Cravings (ice, clay, dirt, starch, chalk, etc.)_____

6. Do you use a salt substitute? Yes / No Purchase salt-free foods? Yes/ No
   _____

7. Do you use salt in cooking? Yes / No At the Table? Yes / No

8. Do you drink or eat any type of high protein supplement? Yes / No
   If yes, please list name of product_____

9. Do you exercise? Yes / No If yes, how often do you exercise and what type?
   _____

10. Have you ever followed any other special diet? Yes / No If yes, what type of Special Diet are you on? _____
    How well do you follow the meal plan? ____Closely ___Followed some __Not at all

11. Do you have any concerns relating to your diet or nutrition? Yes / No
    If yes, please explain: _____
    _____
    _____

Please list your Typical Meal Pattern below:

Number of meals daily: _____ Number of Snacks daily: _____

Breakfast:

_____

Snack: _____

Lunch:

_____

Snack: _____

Supper:

_____

Snack:_____

Summary of Food Frequency

Beverages (please specify type and average amount /day or week):

Milk: _____
Milk Products (cheese, yogurt, etc): _____
Soda/Cola: _____
Alcohol: _____
Fruit Juices: _____
Other Beverages (coffee/tea): _____

Protein Foods (please specify type and average amount /day or week):

Meat/Fish/Poultry: _____
Eggs: _____
Peanut Putter: _____
Frozen Meals: _____
Luncheon Meats: _____

Other Foods (please specify type and average amount /day or week):

Snacks/chips: _____
Dried Beans/Peas: _____
Potatoes/Tomatoes: _____
Bananas/Oranges: _____
Nuts/Seeds: _____
Other Fruits: _____
Other Vegetables: _____