

DIET/WEIGHT HISTORY

Who shops for groceries in your household? _____

Number of members in your household? _____

How many times a week do you eat in a restaurant? _____

What types of restaurants do you frequent most often? _____

When do you usually eat in a restaurant?

Breakfast Lunch Dinner Other: _____

How often do you have an alcoholic beverage?

Daily 4-6 days/week 1-3 days/week 1-2 days/month Never

What is your beverage of choice?

Beer Wine Hard liquor

What are your favorite foods? _____

What do you usually eat at the following meals?

Breakfast	Noon	Evening
Morning Snack	Afternoon Snack	Evening Snack

Do you have any food allergies? _____

Do you drink 64 ounces of water daily? Y N

Do you drink regular coffee? Y N How much per day? _____

Do you drink: regular soda diet soda Kind: _____

If yes, how much soda do you drink in a day? _____

Do you eat breakfast every day? Y N

Do you have three meals in 24 hours? Y N

Do you have a protein source at breakfast? Y N

Do you think your portions are larger than they should be? Y N

Do you try to make healthy choices when eating in restaurants? Y N

Do you eat 2 different fruits each day? Y N

Do you eat 2 different vegetables each day? Y N

Do you often eat desserts, ice cream, candy, and/or baked goods? Y N

Do you frequently consume high fat items like fried food, full fat salad dressings, processed meats, etc.? Y N

Do you take a daily multi-vitamin? Y N

Do you eat slowly and chew food thoroughly? Y N

Do you sip beverages slowly? Y N

If there is anything else you would like the dietitian to know about your past or present eating/dieting, please describe below.
