



Hunterdon Healthcare

Center for Nutrition & Diabetes Management

Wescott Medical Arts Center

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www.hunterdonhealthcare.org

Nutrition Self-Assessment

Please fill out all of the information on this form and bring it to your nutrition appointment.

Name: _____ Date: _____

List any medication you take.

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Vitamins/Minerals:

Muti vitamin _____ Dose: _____

Calcium _____ Dose _____

Vitamin D _____ Dose: _____

Other _____ Dose: _____

Herbal supplements: _____ Dose: _____

List any Food and/ or Drug allergies:

Medical History (please circle those that apply)

- | | | |
|--------------------------|-------------------------|-----------------------------------|
| Diabetes | Pre Diabetes | Family History Diabetes |
| Gestational Diabetes | Overweight/Obesity | Sleep Apnea |
| High Cholesterol | High Blood Pressure | Heart Disease |
| Congestive Heart Failure | Eating Disorder | Celiac Disease |
| Irritable Bowel Syndrome | Osteoporosis/Osteopenia | Polycystice Ovary Syndrome (PCOS) |
| Non-healing wound(s) | | |
| Others _____ | | |

Do you experience: _____ periods of not breathing when sleeping _____ snoring
_____ morning headaches _____ awakening not rested in the morning _____ other

Exercise

Do you exercise regularly? _____ No _____ Yes

Type of exercise: _____

How often do you exercise: _____

How long do you exercise: _____

List any limitations with exercise: _____

Have you ever had an exercise stress test: _____ If so, when: _____

Learning Style

Do you prefer to learn by: reading discussion internet DVD/ CD
 hands on training

Have you had previous nutrition education? No Yes
If yes, where and how long ago: _____

Do you have any problems learning about medical conditions because of difficulty understanding written information? No Yes

Are you confident in filling out medical forms independently? No Yes

How often do you have someone help you read hospital materials? Often Never

Intake History

The most important things I want to learn today are:

- 1. _____
- 2. _____
- 3. _____

Do you drink alcohol? No Yes If so, how much? _____

Do you smoke? No Yes If so, how much? _____

Do you have any religious or cultural observations that affect how you eat? _____

If yes, please explain: _____

Do you feel deprived regarding food and meals? No Yes

Do you feel uncomfortable in social situations related to food? No Yes

Do you feel constantly concerned about food and eating? No Yes

Please explain: _____

Who prepares your meals? _____

How is your food usually prepared? Fried Baked Grilled Broiled
 Other _____

How many times a week do you eat away from home? _____

Fast Food Restaurant Take out Other

Do you: Skip meals Nibble between meals Eat rapidly

Have food cravings Use convenience foods Eat unplanned meals

Other: _____

Based on one day:

How much milk or yogurt do you consume? _____

How many vegetables? _____

How many fruits? _____

How much water do you drink in one day? _____

What are your main beverages? _____

Height: _____ Current Weight: _____ Usual Body Weight: _____
Goal Weight: _____ Highest Weight: _____ Lowest Weight: _____

Please record a "usual" day.
What kind of food? How much food?

BREAKFAST Time _____	MORNING SNACK Time _____
LUNCH Time _____	AFTERNOON SNACK Time _____
DINNER Time _____	EVENING SNACK Time _____

_____, R.D. Date: _____