Nutrition Questionnaire

10 years and above

Patient Name _____ Today's Date _____

Date of Birth _____ Patient Age _____

Are you allergic to any food or drinks? O Yes O No

If yes, allergic reaction to what? _____

How do you react? O Rash O Swelling O Itching / Tingling (mouth, throat, ears)

O Difficulty breathing O Vomiting

Do you take any vitamins/minerals or food supplements? O Yes O No

If yes, which ones? _____

Do you have any concerns about your weight or physical appearance? O Yes O No

If yes, please list your concerns: _____

How many days per week do you eat:

Breakfast: _____ Lunch: _____ Dinner: _____ Snacks: _____

Do you eat out (restaurants, take-out, fast food, etc.)? O Yes O No How often? _____

List restaurants usually chosen: _____

Do you take lunch to school or buy lunch at school? _____

Examples of food choices: _____

_____

Do you drink any caffeinated beverages? O Yes O No How often? _____

O Coffee O Hot tea O Iced tea O Energy drinks O Blended coffee beverages O Soda

Do you drink any sugar containing beverages? O Yes O No How often? _____

O Juice O Electrolyte drinks (Gatorade, Powerade) O Blended coffee beverages O Soda
O Energy drinks O Lemonade/Limeade O Sweetened iced tea O Other _____

Do you eat snacks? O Yes O No

Most common food choices for snack: _____

Do you currently exercise/participate in sports? O Yes O No

How many days per week and minutes per day do you exercise or play sports? _____

What types of physical activity do you most enjoy? _____