Reproductive Medicine Associates of Connecticut

Carolyn Gundell, MS

NUTRITION QUESTIONNAIRE

Please bring to first nutrition appointment Date_____

Patient Name_____ Date of Birth_____

Partner's Name_____ Date of Birth_____

Address_____
Street City State Zip

Home Tel #_____Cell # _____Email_____

1. Please list your ethnic background? (for purpose of determining health risk factor)_____

2. How are you hoping to benefit from this nutrition session?

_____

_____

3. Do you have any food allergies or other allergies? Yes ☐ No ☐ Epi-pen Yes ☐ No ☐

Please List_____

4. Do you have any food intolerances? Yes ☐ No ☐ Gastro-intestinal conditions? Yes ☐ No ☐

Please explain e.g constipation, acid-reflux, flatulence, diarrhea, IBS, other

_____

5. Do you have cultural or religious food preferences? Yes ☐ No ☐

Please explain_____

Are you vegetarian? Yes ☐ No ☐ Vegan ☐ Lacto ☐ Lacto-Ovo ☐ Pollo ☐ Pesco ☐

6. Are you presently following a specific diet? Yes ☐ No ☐

Please explain:_____

7. Please list any present medical/health concerns? Past surgeries?

_____

_____

_____

8. Please list any **MEDICATIONS** that you are presently taking and reason prescribed:

_____

_____

_____

9. Please list any vitamins **and/or** supplements that you are presently taking and reason prescribed.
eg. fertility supplements, herbs, flax, fish, protein powders, vitamins, etc.

_____

_____

_____

BEVERAGES

10. Indicate all beverages that you drink

milk ☐ water ☐ juice ☐ reg soda ☐ diet soda ☐ gatorade ☐ seltzer ☐ herbal bev ☐

coffee ☐ tea ☐ decaf ☐ caffeine ☐ herbal ☐ wine ☐ alcohol ☐

Other _____

MILK

11. Do you drink milk? Yes ☐ No ☐ in coffee only ☐ in cereal only ☐

Cow's milk - skim ☐ 1% ☐ 2% ☐ Lactose Free ☐ Whole fat ☐ Almond milk ☐

Soy milk: plain ☐ vanilla ☐ chocolate ☐ Rice beverage ☐ plain ☐ flavored ☐

Do you eat yogurt? Yes ☐ No ☐ What kind_____

PROTEIN

12. Indicate which protein items that you eat

Chicken ☐ Beef ☐ Turkey ☐ Fish ☐ Tuna fish ☐ Nut/Peanut butters ☐ Beans/legumes ☐

Tofu ☐ Eggs ☐ Almond Butter ☐ Nuts ☐ Seeds ☐ Edamame ☐ Cheese ☐

FRUIT

13. How many times do you eat fresh fruit?

Per <u>Day</u> Never ☐ 0-1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+ ☐

Per <u>Week</u> Never ☐ 0-1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+ ☐

VEGETABLES

14. How many times do you eat vegetables, excluding salad?

Per Day Never ☐ 0-1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+ ☐

Per Week Never ☐ 0-1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+ ☐

GRAINS/ BREADS

15. Indicate which item(s) you will eat

white bread ☐ whole wheat bread ☐ white rice ☐ cereal ☐ waffles ☐ pancakes ☐ brown rice ☐

pasta ☐ bagel ☐ english muffins ☐ tortilla ☐ quinoa ☐ barley ☐ buckwheat ☐ oats ☐

steel cut oats other_____

FATS

16. Indicate what kind of fat spread you use?

Butter ☐ stick margarine ☐ tub spread ☐ olive oil ☐ vegetable oil ☐ canola oil ☐

How often? Each meal ☐ Only on certain foods ☐ Cooking only ☐

LIFESTYLE

17. Do you work? Yes ☐ no ☐

What is your occupation?_____

18. Type of work: sitting ☐ active ☐ How many days /week _____hours/week? _____

Do you rotate shifts? Yes ☐ No ☐ Please indicate - Do you work 1st ☐ 2nd ☐ or 3rd shift ☐

19. How many hours of TV watching _____ per day? Video Games _____ per day?

20. Time on computers? _____ per day? Is there a television in the bedroom? Yes ☐ No ☐

21. What time do you go to sleep at night? _____ Wake? _____ Nap? _____

22. Do you wake rested? Yes ☐ No ☐ Do you snore? Yes ☐ No ☐

Are you a restless sleeper? Yes ☐ No ☐

Have you been diagnosed with sleep apnea? Yes ☐ No ☐ Do you use a c-pap? Yes ☐ No ☐

23. Do you participate in regular structured activity? Yes ☐ No ☐

What ? _____

How often?_____

24. What other type of activities do you enjoy doing?

_____

_____

SAMPLE FOOD CHOICES

25. How often do you eat in restaurants or take out? _____ times / week _____ per month

Where do you go? _____

_____ _____

_____

26. Please list **all** snack choices available to you at home and work

_____

_____

_____

27. Please list **typical** food choices that you choose for breakfast, lunch, and dinner:

BREAKFAST	LUNCH	DINNER
Time: _____	Time: _____	Time: _____
Do you often skip breakfast? Yes ☐ No ☐	Do you often skip lunch? Yes ☐ No ☐	
How often do you eat breakfast?: __Every morning_____	Do you eat lunch at your desk? Yes ☐ No ☐	
Are you an "eat on the go" type?: Yes ☐ No ☐		
Food Choices		

Additional
Comments_____
_____
_____
_____
_____
_____
_____
_____

Name: _____

Family medical history: Please indicate if you or your family member has condition listed.

				Father's side of family						Mother's side of family				
	Yourself	Sisters	Brothers	Father	Father's brothers	Father's sisters	Paternal Grandfather	Paternal Grandmother		Mother	Mother's brothers	Mother's sisters	Maternal Grandfather	Maternal Grandmother
PCOS	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Insulin Resistance	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Pre-Diabetes/ Diabetes	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Gestational Diabetes	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Fatty Liver	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Thyroid Concerns	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Overweight	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Gastric Bypass/Lapband	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
GERD/Acid reflux	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Irritable Bowel	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Food Allergy	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Underweight	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Irregular Periods	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐