Reproductive Medicine Associates of Connecticut

NUTRITION QUESTIONNAIRE

Please bring to first nutrition appointment Date_____

Patient Name_____ Date of Birth_____

Partner's Name (if applicable) _____ Date of Birth_____

Patient's Mother/Father (adolescents)_____

Address_____
Street City State Zip

Home Tel #_____Patient Cell # _____Email_____

1. Please list your ethnic background? (for meal planning purposes)_____

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

If yes, please list: _____

5. Do you have any Gastro-intestinal conditions? ☐ Yes ☐ No

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

_____

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

Please explain_____

7. Are you vegetarian ☐ Yes ☐ No
Please circle: Vegan, Lacto, Lacto-Ovo, Ovo, Pescetarian, Pollotarian

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

If you marked yes, please explain:

_____

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

_____

_____

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

_____

_____

_____

11. Please list all vitamins **and/or** supplements that you are presently taking and reason prescribed.
Ex; fertility supplements, herbs, flax, fish, protein powders, vitamins, etc.

_____

_____

_____

BEVERAGES

12. Indicate all beverages you drink

☐ water ☐ juice ☐ soda reg ☐ diet soda ☐ gatorade ☐ coffee ☐ tea

☐ seltzer ☐ wine ☐ alcohol ☐ herbal bev

Other _____

DAIRY/DAIRY SUBSTITUES

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

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

Soy milk - ☐ plain ☐ flavored ☐ **Coconut Milk**

Rice beverage ☐ plain ☐ flavored ☐ **Almond Milk**

Do you eat yogurt? What Kind_____

PROTEIN
14. Indicate which protein items that you eat:

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

☐ Eggs ☐ Nuts ☐ Seeds ☐ Edamame ☐ Cheese ☐ Tofu ☐ Beans/ legumes

FRUIT
15. 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
16. 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
17. Indicate which grains/breads you eat on a consistent basis:

☐ white bread ☐ whole-wheat bread ☐ white rice ☐ brown rice ☐ cereal

☐ waffles ☐ pancakes ☐ pasta ☐ bagel ☐ tortilla ☐ English muffins

☐ quinoa ☐ barley ☐ buckwheat ☐ oats ☐ steel cut oats

☐ roti/chappati ☐ Idli ☐ Dosa

FATS
18. Indicate which kind of fat spread you use?

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

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

LIFESTYLE
19**.** Are you a student? ☐ Yes ☐ No

20. Do you work? ☐ Yes ☐ No
What is your occupation ? _____

21. Type of work - ☐ sitting ☐ active How many days /week _____ hours/week? _____

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

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

23. Time on computers? _____per day? Is there a television in the bedroom? ☐ Yes ☐ No

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

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

Are you a restless sleeper? ☐ Yes ☐ No

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

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

What activity?_____

How often?_____

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

_____

_____

28. Are you a smoker? ☐ Yes ☐ No If so how many cigarettes per day? _____

Do you use marijuana? ☐ Yes ☐ No Do you use e-cigarettes? ☐ Yes ☐ No

Does your partner smoke? ☐ Yes ☐ No

SAMPLE FOOD CHOICES

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

Where do you go? _____

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

_____

_____

_____

31. Answer the following questions about your meals throughout a typical day:

BREAKFAST
Time_____

Do you skip breakfast?

☐ Yes ☐ No

Do you "eat on the go" ?

☐ Yes ☐ No

LUNCH
Time: _____

Do you eat lunch at your desk?

☐ Yes ☐ No

Do you skip lunch?

☐ Yes ☐ No

DINNER
Time: _____

Do you skip Dinner?

☐ Yes ☐ No

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

Breakfast	Lunch	Dinner

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	Fathers brothers	Fathers sisters	Paternal Grandfather	Paternal Grandmother		Mother	Mothers brothers	Mothers sisters	Maternal Grandfather	Maternal Grandmother
PCOS														
Pre-Diabetes Insulin Resist														
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														