UF | Student Health Care Center
UNIVERSITY of FLORIDA

NUTRITION QUESTIONNAIRE

PATIENT INFORMATION

NOTE: In order to be seen at this facility, patients under age 18 must have a parent/guardian sign a Consent and Authorization form.

Name (last, first): _____ **UF ID:** _____

Other Names/Aliases, Preferred Pronouns (optional): _____

Date of Birth: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female Gender Identity (optional):_____
(MM/DD/YYYY)

I live: ☐ On Campus ☐ Off Campus **Year In School:** ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Grad Student

Major:_____

Referred by: ☐ Self ☐ RecSports ☐ Health Care Provider ☐ Other:_____

Have you seen a Nutritionist/Registered Dietitian before? ☐ Yes ☐ No If so, who and when? _____

Why do you want to see a nutritionist? Check all that apply.

- ☐ Anemia
- ☐ Diabetes
- ☐ Disordered eating concerns
- ☐ General healthy eating concerns
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel syndrome
- ☐ Vegetarian or vegan eating
- ☐ Want to gain weight
- ☐ Want to lose weight
- ☐ Other: _____

MEDICAL HISTORY

Are you currently being treated for a medical condition? ☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

Are you taking any prescription medications, over-the-counter medications, vitamins and/or supplements? ☐ Yes ☐ No ☐ Not Sure

If yes, please list: _____

Do you have any family history of diabetes? ☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

Do you have any family history of high blood pressure? ☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

Do you have any family history of high cholesterol? ☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

QUESTIONS

1. Height:_____feet _____inches Present weight:_____pounds Usual weight:_____pounds

   Weight when graduated high school:_____pounds Desired weight range:_____pounds to _____pounds

2. How often do you weigh yourself? ☐ More than once a day ☐ Daily ☐ Almost Daily ☐ Weekly ☐ Rarely ☐ Never

3. Have you ever had concerns about your weight? ☐ Yes (If yes: ☐ Overweight ☐ Underweight) ☐ No

   Comments: _____

4. Which of the following best describes your family?
   - ☐ As a group, my family is not overweight or obese.
   - ☐ As a group, some members of my family are overweight or obese.
   - ☐ As a group, most members of my family are overweight or obese.
   - ☐ I am not sure.

5. How would you generally describe your eating habits? ☐ Good ☐ Fair ☐ Poor
6. How often do you eat fewer than 3 times a day? ☐ Daily ☐ Almost Daily ☐ Weekly ☐ Rarely ☐ Never
7. Does your food intake or weight feel out of control? ☐ Yes ☐ No
8. How would you rate your appetite recently? ☐ Hearty ☐ Normal ☐ Moderate ☐ Poor

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9. How many times a day do you have a meal or snack? ☐ 0-3 times ☐ 3-5 times ☐ 5 or more

Describe your typical snack or meal: _____

_____

10. On average, how much water do you consume each day? ☐ 0-16 oz. ☐ 16-32 oz. ☐ 32-48 oz. ☐ 48-64 oz. ☐ 64 oz. or more

11. On average, how many days per week do you consume alcoholic drinks? Circle your answer. 0 1 2 3 4 5 6 7

12. How many drinks do you consume when you drink? (1 drink= 1.5 oz. of 80 proof liquor, 5 oz. wine, or 12 oz. beer)

☐ Do not drink ☐ 1-2 drinks ☐ 3-5 drinks ☐ 6-8 drinks ☐ 9 or more drinks

13. Do you have food allergies? ☐ Yes ☐ No ☐ Not Sure

If yes, list foods you are ALLERGIC to: _____

14. Are you on a special diet? ☐ Yes ☐ No Who prescribed or suggested this diet for you? ☐ Doctor ☐ Friend ☐ Family ☐ Self

Please specify type: ☐ Vegetarian ☐ Low-carb ☐ Diabetic ☐ Gluten-free ☐ Other: _____

15. How many meals do you eat per week: At home:_____ Dining hall:_____ Restaurant:_____ Work: _____

Fast food chain:_____ Sorority/Fraternity:_____ Other:_____

16. How many days per week do you participate in moderate to vigorous activity (brisk walking, jogging or aerobics) for at least 10 minutes?

Circle your answer. 0 1 2 3 4 5 6 7

17. On days you do moderate to vigorous activity, how much total time do you spend? ☐ 10-30 mins ☐ 30-60 mins ☐ 60 mins or more

18. What do you hope to achieve as a result of nutrition counseling? _____

_____

_____

19. **Please circle your answers on the1-5 scale:**	**Not At All**				**Extremely**
How important is change to you?	**1**	**2**	**3**	**4**	**5**
How confident are you to make this change at this time?	**1**	**2**	**3**	**4**	**5**

20. What barriers, if any, stand in the way of you achieving your nutritional goals? Check all that apply.

☐ Time ☐ Hunger ☐ Stress ☐ Influence of others ☐ Money ☐ Don't like to exercise ☐ Not sure what to eat ☐ Not a priority

☐ Lack of motivation ☐ Other, please list: _____

24 HOUR FOOD RECORD

Please provide a list of ALL food and beverages you ate in a 24-hour time period. Try to be as specific as possible: Indicate food that is homemade or give the name of the restaurant or brand, as well as specifying portion sizes (for example: 1 cup, 1 slice or 1 handful). PLEASE USE THE BACK OF THIS SHEET AS NEEDED.

BREAKFAST – # TIMES / WEEK: 0 1 2 3 4 5 6 7

SNACK

LUNCH – # TIMES / WEEK: 0 1 2 3 4 5 6 7

SNACK

DINNER – # TIMES / WEEK: 0 1 2 3 4 5 6 7

SNACK