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Comprehensive Family Nutrition
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Name: ______________________________________ Date: ______________

1. Please list any current medical problems:
   ____
   ____
   ____
2. List all past medical problems:____
   ____
   ____
3. Please tell me about your weight history: stable ___, up and down ____ # lbs ____
4. Please list all medications you are currently taking:___________________________
   ____
   ____
5. Please list all vitamin/mineral supplements or herbs you are currently taking:
   ____
   ____
6. Do you exercise? Yes No
   If yes what type of exercise and how often?
   ____
   ____
7. Do you experience problems with constipation? ___ yes ___no
8. When do you wake up in the morning? ______________
9. When do you go to sleep at night? ________________

   Eating Habits:

10. Please tell me about some of your eating habits:
    How often do you eat out at restaurants? __________________________________
    How often do you eat at other peoples homes?_______________________________
    I buy meals at school ____ fast food restaurants_____, other____________
    I have a special diet? Yes No Type of diet__________________________________
    How many meals do you eat a day? _______________________________________
    How often do you skip meals? ________________________
    What meal or meals do you tend to skip? Breakfast Lunch Dinner
    How many snacks do you eat a day? ______________________________________
    What times of day do eat snacks? ____
    What kind of snacks do your like to eat? ____________________________________
    What are your favorite meal (s)? ____
    What type of beverages do you like to drink? _______________________________
    How many glasses of water do you drink/day?________________________________
    Please list any question or concerns you may have, you may use the back of this page.

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