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Nutrition Questionnaire for Women

1. Name: _____
2. Age: _____ Date of birth _____
3. Weight _____ lbs. Date: _____ Height: _____ inches Date: _____
4. Please list any current medical problem you have: _____

5. List all past medical problems: _____

6. Family history: __Heart Disease __ Breast Cancer __Diabetes __ Osteoporosis
7. Have you ever had a bone scan? Yes No Results if yes: _____
8. Do you know the values of your last cholesterol? _____, LDL? _____, HDL? _____, triglycerides? _____ Date _____
9. How is your blood pressure? ___high, ___low, ___normal.
10. Please tell me about your weight history: stable ____, up and down ____ # lbs
11. Have you ever been on a diet to lose weight? Yes No
If yes what type of diets have you tried? _____
Were you successful in losing weight? Yes No
How much weight did you lose? _____
Were you able to maintain the weight loss? Yes No
12. Please List all medications you are currently taking: _____

13. Do you take the birth control pill? Yes no
14. Do you take hormone replacement? Yes No
15. Please list all vitamin/mineral supplements or herbs you are currently taking: _____

16. Do you take Calcium Supplements? Yes No # mg/day _____.
If yes what type of Calcium Supplement do you take? _____
17. Do you exercise? Yes No
If you exercise what type of exercise do you do and how often do you exercise?

18. Do you smoke? Yes No # cigarettes/ day ____ /week ____.
19. Are you under a lot of stress in your life? yes no
20. Do you tend to eat more or less when you feel stressed? More less
21. What foods do you tend to eat when you feel a lot of stress? _____

22. Do you experience problems with constipation? ___yes ___no

Eating Habits:

23. Please tell me about some of your eating habits:

How often you eat out at restaurants? _____

How often do you eat at other peoples homes? _____

Do you bring your lunch to work or buy it? _____

How many meals do you eat/day? _____

How many snacks do you eat/day? _____

What time of day do you like to eat snacks? _____

What kind of snacks do you like to eat? _____

What type of beverages do you like to drink? _____

How many glasses of water do you drink/day? _____

Do you drink coffee/tea? Yes No How many cups/day? _____

Do you drink alcohol? Yes No

If yes how many cups/day _____ cups/week _____ cups/month _____

24. Please tell me a little about your food shopping habits?

Do you make a shopping list before you go shopping? yes no

How many time a week do you stop to buy food? ____ /week

Does someone else do the food shopping? yes no If yes who? _____

Where do you do most of your grocery shopping? _____

Do you tend to snack while you are grocery shopping? Yes no

If yes what do you snack on? _____

Do you read labels when you shop? yes no

Is there anything about your grocery shopping habits that you would like my help to change or improve? yes no

If yes what would like help with? _____

25. What goals would like to work on around your nutrition, diet and/ or lifestyle?

26. Is there anything else you would like me to know?