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Comprehensive Family Nutrition
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Questionnaire for Men

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 ___Diabetes __ Osteoporosis
7. Do you know the values of your last cholesterol? ____, LDL? _____, HDL?_____, triglycerides?_____ Date_____
8. How is your blood pressure? ___ high, ____low, ____normal.
9. Please tell me about your weight history: stable ___, up and down ____ # lbs
10. 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
11. Please List all medications you are currently taking:_____
    _____
    _____
12. Please list all vitamin/mineral supplements or herbs you are currently taking: _____
    _____
    _____
13. Do you take Calcium Supplements? Yes No # mg/day_____.
    If yes what type of Calcium Supplement do you take?_____
14. Do you exercise? Yes No
    If you exercise what type of exercise do you do and how often do you exercise?
    _____
    _____
15. Do you smoke? Yes No # cigarettes/ day____ /week____.
16. Are you under a lot of stress in your life? yes no
17. Do you tend to eat more or less when you feel stressed? More less
18. What foods do you tend to eat when you feel a lot of stress? _____
    _____
19. Do you experience problems with constipation? ___yes ___no

    Eating Habits:
20. 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_____

21. Please tell me a little about your food shopping habits?
    Who does the shopping in your household? _____
    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 also 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? _____

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

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