THE OREGON CLINIC
GASTROENTEROLOGY

Nutrition Services – Patient Questionnaire

DATE: _____

Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____

Please list your health concerns and goals for today's visit:

Weight History (please skip this section if not related to your visit)

Would you like to be weighed at your visit? ❑ Yes ❑ No

Have you had recent weight changes that concern you? ❑ Yes ❑ No

If yes, please explain:

Please provide additional information that might help us understand your weight health:

Supplements

Please list any supplements (vitamins, minerals, probiotics, herbs, or other) that you take regularly:

Digestive Health History

Please indicate how often you experience the following symptoms: (check one for each)

Abdominal pain	❑ Often	❑ Sometimes	❑ Rarely
Bloating	❑ Often	❑ Sometimes	❑ Rarely
Constipation	❑ Often	❑ Sometimes	❑ Rarely
Diarrhea	❑ Often	❑ Sometimes	❑ Rarely
Gas	❑ Often	❑ Sometimes	❑ Rarely
Heartburn	❑ Often	❑ Sometimes	❑ Rarely
Nausea	❑ Often	❑ Sometimes	❑ Rarely
Loss of Appetite	❑ Often	❑ Sometimes	❑ Rarely
Vomiting	❑ Often	❑ Sometimes	❑ Rarely

Do you link digestive symptoms with eating certain foods? ❑ Yes ❑ No
If yes, please explain:

Do you have any food allergies or intolerances? ❑ Yes ❑ No
If yes, please explain:

How often do you have a bowel movement? _____

Check if you have any of the following GI related conditions:

❑ Allergies (please specify): _____
❑ Anemia
❑ Anxiety
❑ Diabetes
❑ Irritable Bowel Syndrome (IBS)
❑ Skin condition (eczema, dermatitis, psoriasis, hives)
❑ Arthritis / Joint pain
❑ Depression
❑ Inflammatory Bowel Disease
❑ Kidney stones / Gallstones
❑ Thyroid condition
❑ Other: _____

Please check all that apply:

❑ I have a family history of digestive issues
❑ I have high stress levels
❑ I sleep less than 6 hours per night
❑ I do not exercise
❑ I do not eat fermented foods
❑ I dislike vegetables
❑ I use antacids regularly (past or present)
❑ I need antibiotics regularly (past or present)
❑ I use non-steroidal anti-inflammatory medication regularly (past or present)

Food History

How many meals do you eat per day? ❑ 1 ❑ 2 ❑ 3 ❑ More than 3

Do you skip meals often? ❑ Yes ❑ No

Do you follow a special diet? ❑ Yes ❑ No
If yes, please describe: _____

What beverages do you drink? (mark all that apply)

❑ Water Ounces Daily: _____
❑ Sparkling Water Ounces Daily: _____
❑ Juice Ounces Daily: _____
❑ Milk Ounces Daily: _____
❑ Coffee Ounces Daily: _____
❑ Tea Ounces Daily: _____
❑ Regular Soda Ounces Daily: _____
❑ Diet Soda Ounces Daily: _____

Do you drink alcohol? ❑ Yes ❑ No If yes, describe: _____

Do you have trouble accessing healthy foods? ❑ Yes ❑ No

Who does the grocery shopping and meal preparation? _____

Do you like to cook? ❑ Yes ❑ No

Eating style: (mark all that apply)

❑ Fast Eater
❑ Negative relationship with food
❑ After dinner snacking
❑ Feeling disgusted or guilty after overeating
❑ Travel frequently
❑ Rely on fast food/packaged foods
❑ Poor meal or snack choices
❑ Eat to maintain weight or image
❑ Mindless eater
❑ Emotional eater (stressed, bored, sad, etc.)
❑ Eat too much
❑ Late night eater
❑ Dislike healthy food
❑ Do not plan meals
❑ Confused about nutrition and/or diets
❑ Eat for athletic performance

Please describe a typical day of eating

Breakfast	Lunch	Dinner
Snack	Snack	Snack

Are you ready to change the way you eat? ❑ Yes ❑ No

Patient Signature: _____ Date: _____