THE OREGON CLINIC

Gastroenterology

Specialty Medicine with Commitment, Care and Compassion

Nutrition Questionnaire

Date:

Last	First	Prefer to be called
Name:		

Email:	Date of Birth:	Age:

Referred by:
Primary Care Provider/Physician:
Specialist/Other Health Care Provider:

Medical/Health Conditions:

- ☐ Anxiety/Depression
- ☐ Abdominal Pain
- ☐ Allergies/Asthma
- ☐ Cancer Type & Treatment _____
- ☐ Celiac Disease
- ☐ Cirrhosis of the Liver
- ☐ Constipation
- ☐ Diabetes Type 1 or 2 (circle)
- ☐ Diarrhea
- ☐ Gas/Bloating
- ☐ Gastroparesis
- ☐ GERD/Reflux/Heartburn
- ☐ High Blood Pressure
- ☐ Hyperlipidemia
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Morbid Obesity (BMI >40)
- ☐ Nausea
- ☐ Obesity (BMI 30.0-39.9)
- ☐ Vomiting
- ☐ Weight Loss, Unintentional
- ☐ Other: _____
- ☐ Other:_____

Family Medical History:

Reason for Today's Visit:

Nutrition History and Data:

Height:	Current Weight:	Desired Weight:
High Weight: (past 10 years)	Low Weight: (past 10 years)	Usual Adult Weight Range:
In the past year, have you LOST or GAINED weight? (circle) NO YES How much?		
Ever been on a weight loss diet? (circle) NO YES		

Prescription & Over the Counter Medications:
Nutritional Supplements: **(Vitamins, Minerals, Herbals)**

General Information:

Who lives with you?		
Occupation:		Work/School Hours:
How much stress are you experiencing? (please circle)	Low Stress 1 2 3 4 5 6 7 8 9 10 High Stress	
Do you sleep well at night?	YES NO Sometimes	Hours per night?
How often do you exercise? (type and times per week)		
Tobacco History:		

Diet History:

Food Allergies:
Food Intolerances:
How much water do you drink daily?
Do you drink alcohol? YES NO What types and how often?
How often do you eat out or get takeout each week?
How often do you go to the store for food?
Who does the cooking?
Foods that you eat in large quantity?
Do you have trouble accessing healthy food?

What barriers, if any, stand in the way of you achieving your nutrition goals?

☐ Time	☐ Influence of others
☐ Hunger	☐ Cost of food
☐ Stress	☐ Don't like to exercise
☐ Pain	☐ Other (list): _____

Anything else you think would be helpful for the dietitian to know about you?

Describe what you eat and drink on a typical day:

Breakfast	Lunch	Dinner
Morning Snack	Afternoon Snack	Bedtime Snack

Food Frequency:

Food	Serving Size	Servings per day	Servings per week
Milk/Yogurt	1 cup (8oz.)		
Cheese	1½ oz.		
Cottage Cheese	½ cup		
Fruit	1 whole or ~½ cup chopped		
Fruit Juice	6 oz.		
Vegetables	1 cup raw, ½ cup cooked		
Meat/Protein/Nuts	3oz meat/protein, ¼ cup nuts, 2 TBSP Peanut Butter		
Bread	1 slice bread or small bagel		
Rice/Pasta	½ cup		
Cereal	1 cup		
Beverages	1 cup (8oz.)		
Fats, Oils, & Dressings	1 TBSP		
Sweets	Varies		