THE OREGON CLINIC

Nutrition Services – Patient Questionnaire

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

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 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
❑ Eating disorder or disordered eating
❑ Irritable Bowel Syndrome (IBS)
❑ Arthritis / Joint pain
❑ Depression
❑ Inflammatory Bowel Disease
❑ Kidney stones / Gallstones
❑ Thyroid condition
❑ Skin condition (eczema, dermatitis, psoriasis, hives)
❑ 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: _____	❑ Coffee	Ounces Daily: _____
❑ Sparkling Water	Ounces Daily: _____	❑ Tea	Ounces Daily: _____
❑ Juice	Ounces Daily: _____	❑ Regular Soda	Ounces Daily: _____
❑ Milk	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
❑ Feeling disgusted or guilty after overeating
❑ Travel frequently
❑ Eat to maintain weight or image
❑ Mindless eater
❑ Late night eater
❑ Do not plan meals
❑ Confused about nutrition and/or diets

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: _____

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