Basic Nutrition Questionnaire

Have you ever been told you have High Cholesterol or Triglycerides? YES / NO

Have you ever been diagnosed with High Blood Pressure? YES / NO

Have you been Diagnosed as Diabetic? YES / NO

Have you been Diagnosed with a bleeding disorder or take blood thinners? YES/NO

Have you been diagnosed as Pre-Diabetic or Metabolic Syndrome? YES / NO

How many days a week do you skip a meal? (3/meals/day) _____

How many "fast food', "refined food", or "pre-prepared" meals to you eat per week?

(0) (1-3) (4-6) (7+)

How many servings of fruit do you eat per day?

(0-1) (2-3) (4-5)

How many servings of vegetables to you eat per day?

(0-1) (2-3) (4-5)

Do you regularly drink 1 or more per day of the following: (circle all that apply)

Soda Diet Soda Coffee Juice Milk Alcohol

How many servings of refined sugar do you eat per day? (Candy, Cookies, Cake, etc)

(0-1) (2-3) (4-5)

Please list all nutritional supplements/vitamins you take regularly:

(Staff can photocopy a list if you have one)

Supplement Name/Type	Frequency	Brand or Where Purchased
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT SIGNATURE:_____