GUTHRIE COUNTY HOSPITAL

The expertise you need. The personal care you want.

Medical Nutrition Therapy Questionnaire

Name: _____ **Age:** _____

Height: _____ **Weight:** _____

Activity Level:

	Sedentary	< 30 min.
	Moderate	30 min. - 60 min.
	Active	> 60 min.

1. **What do you want to learn meeting with the Registered Dietitian?** _____
2. **Who prepares your meals in your home?** _____
3. **Do you do your own shopping? If not, who does?** _____
4. **How many of each meal do you eat away from home.**

	During the week?	During the weekend?
Breakfast		
Lunch		
Dinner		

List the restaurants where you often eat: _____

6. **How has your weight changed in the last year? Yes No How much?** _____
7. **What do you think is a realistic weight for you (pounds)?** _____
8. **Write how much of each beverage you would consume in <u>one</u> day:**

Coffee _____ Tea _____ Whole Milk _____ Juice _____

Regular soda _____ 2% Milk _____ Diet soda _____ Water _____

1% Milk _____ Skim (nonfat) Milk _____ Alcohol _____ Other _____

10. **How many servings from each group do you eat per week? Use the chart to note how often you eat each type of food.**

Servings Per Day			
Vegetables/Fruit	**1**	**2-4**	**5-6**
Non-starchy Vegetables			
Starchy Vegetables (Potatoes, Peas, Corn)			
Fresh Fruit			
Canned Fruit			
Dried Fruit			
Dairy	**1**	**2-4**	**5-6**
Cottage or Ricotta Cheese			
Any other cheese			
Yogurt/Frozen Yogurt			
Ice Cream & other frozen desserts			
Combination Foods	**1**	**2-4**	**5-6**
Pizza			
Casseroles			
Soups			

Meats	**1**	**2-4**	**5-6**
Salami, bologna, other lunch meats			
Deli ham, turkey or other deli meats			
Ground beef			
Steak / Other beef as main dish			
Ham or pork as main dish			
Sausage			
Bacon			
Turkey or Chicken			
Shrimp, lobster, or scallops			
Salmon, mackerel, or tuna			
Other fish, not fried			
Grains	**1**	**2-4**	**5-6**
Cold breakfast cereal			
Cooked cereal			
Bread, white			
Bread, whole wheat			
Bread, diet or low-calorie			
Bagels or English muffins			
Biscuits or muffins			
Pancakes or waffles			
Flour or corn tortillas			
Rice			
Crackers			
Pasta (spaghetti, noodles, macaroni)			
Snacks/Sweets	**1**	**2-4**	**5-6**
Danish doughnuts, pastry			
Chips (potato, corn, etc.)			
Pretzels			
Popcorn			
Peanut butter			
Peanuts			
Other nuts (any kind)			
Chocolate candy / Other candy			
Cake / Pie			
Cookies / Brownies			
Sugar added to cereal			
Honey, jam or jelly			
Pancake syrup			

11. How often do you eat food that is fried, stir-fried, or sautéed at home? (circle one)

Never Less than once a week Once a week 2-4 times a week 5-6 times a week

12. What kinds of fat do you use for frying and sautéing at home? (circle)

Butter Margarine Olive Oil Cooking Spray (Pam) Shortening or Lard Other_____

13. What kind of spread do you use on foods? (circle)

Butter Regular margarine Lower calorie margarine Other_____

14. Please list the foods and drinks that you have consumed in the <u>past 24 hours:</u>

(Be accurate! Include the name of each food/beverage you eat or drink and how much you eat or drink of that particular item.)

Meal	Time & Place	What did you eat and drink?
Breakfast / 1st meal		
Snack		
Lunch / 2nd meal		
Snack		
Dinner / 3rd meal		
Snack		
Other		

Thank you for completing this questionnaire. Please return this form to Carol Laughery, R.D., L.D. prior to your scheduled appointment date.

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