THE UNIVERSITY OF TEXAS AT DALLAS EMPLOYEE WELLNESS CENTER

HEALTH HISTORY & NUTRITION QUESTIONNAIRE

PERSONAL INFORMATION

Name: ____ __________________ **Date:** ___________________________

Last, First Preferred Name

Age: _______ **Gender Assigned at Birth:** M F **Phone:** ( ) _______-_________ **Net ID:** _____________________

What is the reason for your visit today? ____

Have you seen a Dietitian or a Nutritionist before? Y N **If so, when and why?** _________________________________

MEDICAL HISTORY

Are you currently being treated for a medical condition? If yes, explain:____

____

____

List any food allergies: ____

Do you have a family history of diabetes, high blood pressure, or high cholesterol? If so, please explain: _____________

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NUTRITION & DIET HISTORY

Height: ________**feet** ________**inches** **Present weight:** ______________ **Usual weight:** ______________

How often do you weigh yourself? □More than once a day □Daily □Almost Daily □Weekly □Rarely □Never

Do you have concerns about your weight? □Yes (□Overweight □Underweight) □No

Comments: ____

How would you generally describe your eating habits? □Good □Fair □Poor

Which of the following do you eat on a daily basis? □breakfast □lunch □dinner

How many times a day do you have a snack? □0-3 times □3-5 times □5 or more

How would you rate your appetite recently? □Hearty □Normal □Moderate □Poor

Does your food intake or weight feel out of control? □Yes □No

Do you take vitamins and/or supplements? □Yes □No **If so, what?** ____

Are you on a specific diet? □Yes □No

If yes, please specify type: ____

How many days per week do you participate in moderate to vigorous activity for at least 10 minutes? _____________

What do you hope to achieve as a result of nutrition counseling? ____

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