

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP US EVALUATE YOUR EATING HABITS

1. How many servings of alcohol do you drink per day?	0	1	2	3	4	More
How many servings of alcohol do you drink per week?	0	1	2	3	4	More
2. How many times do you eat out per week?	0	1	2	3	4	More
3. Which meals do you eat each day? (Circle all that apply)	Breakfast		Lunch		Dinner	

4. What kind of snacks do you eat regularly (i.e. chips, soda, fruit)?

5. How often do you eat fried foods? (Circle one) Never Seldom Sometimes Often

6. How many times do you exercise per week? How many minutes is each session?

7. What kind of exercise do you do (i.e. running, aerobics, golf, etc)?

8. List any medications/vitamin supplements that you are taking.

9. Do you have any special circumstances, food allergies or intolerances to consider in meal planning? YES NO

If yes, please explain:

FOR PREGNANT PATIENTS ONLY

Did you have gestational diabetes with any previous pregnancies?		Number of previous pregnancies	Amount of weight gain during previous pregnancies
YES	NO		

At what age did you have your previous child/children?

What is your usual body weight?	Anticipated delivery date?	Are you planning to breast feed?	
		YES	NO

DO NOT WRITE BELOW THIS LINE - TO BE COMPLETED BY DIET COUNSELOR

SUGGESTED SERVINGS	EATEN	ADEQUATE		ASSESSMENT		REMARKS
		YES	NO			
MILK 2-3 Adults/Children 4-5 Pregnant/Lactating 5-6 Pregnant Teens					Adequate May be inadequate in: Calcium, Protein, Riboflavin	
MEAT/PROTEIN 5-7 oz Adults/Children 6-7 oz Pregnant/Lactating 7-8 oz Pregnant Teens					Protein, Iron, Niacin, Thiamin, Zinc	
FRUITS 2-4 Servings					Vitamins A and C, Potassium	
VEGETABLES 3-5 Servings					Vitamins A and C, Folic Acid	
BREADS/CEREAL/GRAINS 6-11 Servings					Iron, Complex Carbohydrate, Niacin, Thiamin, Fiber	

DATE	TYPED OR PRINTED SIGNATURE BLOCK OF DIET COUNSELOR	SIGNATURE
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