BERGEN
GASTROENTEROLOGY • MEDICAL ASSOCIATES

NUTRITION ASSESSMENT FORM

First Name _____ Last Name _____ Date _____

Address _____ Phone _____

Email _____

Physician _____ Birth Date_____

Height _____ Weight _____ Blood Sugar _____

Hgb A1c _____ Cholesterol _____ Triglycerides _____ Blood Pressure _____

What is your main reason for this visit?

_____

In the past year would you say you:

☐ Gained 10 pounds or more ☐ Lost 10 pounds or more ☐ Stayed the same

What would you consider a healthy weight for you? _____

Have you had nutrition counseling in the past? ☐ yes ☐ no

If so, for what health issue?

_____

Do you follow a special diet now? ☐ yes ☐ no

If so, what kind?

_____

How do you decide what foods to eat? ☐ Eat whatever you want ☐ Eat till you're full

☐ Avoid sweet ☐ Limit intake of fats ☐ Limit intake of starch

☐ Other _____

Where Do You Eat Most Of Your Meals? ☐ Kitchen ☐ Car ☐ Living Room ☐ Bedroom

☐ Office ☐ Other _____

Who does the food shopping and preparation?_____

How many people live in your home? _____

How many meals are eaten in a restaurant or from takeout per week?_____

Describe your intake of beer, wine or distilled alcohol:

☐ Daily ☐ 3 times per week ☐ only weekends ☐ none ☐ other_____

List your medications:

_____

List your vitamin/mineral supplements:

_____

List any food allergies:

_____

Check The Type Of Fats You Eat:

☐Butter ☐Margarine ☐Mayonnaise ☐Soft Tub Margarine ☐Olive Oil ☐Corn Oil ☐Salad Dressing

☐Gravy ☐Other Sauces ☐Low Fat Margarines ☐Vegetable Oil ☐Crisco ☐Lard

Estimate the portion size of fats you eat in a typical day? *(Think in terms of spoon sizes-1 pat is 1 teaspoon):*

☐ 10 teaspoons or more ☐ 6-7 teaspoons ☐ 4-5 teaspoons ☐ 3 teaspoons or less

Which of the following are you most likely to choose for dessert? ☐ Cake ☐ Low fat cake or cookies

☐ Cookies ☐ Frozen dessert ☐ Muffins ☐ Sugar free pudding ☐ Fruit ☐ Other_____

PLEASE CHECK HOW OFTEN YOU EAT THE FOLLOWING:

fruit	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
fruit juice	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
candy	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
low fat cookies	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
cookies, cake, doughnuts	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
eggs	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
red meat	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
cold cuts	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
chicken	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
fish	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
frozen TV dinner	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
cheese - cheddar	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
cheese - low fat	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
milk	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
fast foods	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
chips / salty snacks	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
sherbet, ices	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
ice cream	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
frozen yogurt	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
nuts	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
alcoholic drinks	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
dietetic cake or candy	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never
vegetables	☐ Daily	☐ Less than 3x / week	☐ Rarely / Never

What did you eat yesterday?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

When do you find it most difficult to control at you eat? ☐ Before dinner ☐ After dinner

☐ Midmorning ☐ Parties ☐ Restaurants ☐ Periods of stress ☐ Other_____

Describe your exercise program. Please include the type and duration as well as how often in the week.

For GI patients:

List the foods that cause you the most discomfort:

_____

Describe the symptoms you have when you eat those foods:

_____

Office use:

____Md letter

____Billing

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