NUTRITION SERVICES OUTPATIENT
DATA BASE FORM

Please fill out as completely as possible prior to your visit and bring all documents with you at the time of your appointment. Please, also, bring the results of any pertinent lab work with you.

Name: _____

Age:_____ Sex: M or F Ht:___ Current Wt.:_____ Usual Body Wt.: ____

PAST MEDICAL HISTORY

☐ Heart Disease/ Congestive Heart Failure	☐ Colostomy/Illostomy	☐ Peripheral Vascular Disease/Bleeding Disorder	☐ Nutrition Support/ Tube Feeding	☐ Other
☐ High Blood Pressure	☐ Stomach Bowel Prob	☐ Alcohol/Drug Abuse	☐ Malnutrition	☐ Anorexia
☐ Stroke	☐ Liver Disease/Hepatitis	☐ Depression	☐ Decubiti/Wounds	☐ Bulemia
☐ Diabetes	☐ Renal/Dialysis	☐ Parkinson's	☐ Recent Surgery	☐ Diarrhea
☐ COPD/Breathing Prob	☐ Cancer/Chemo/Radiation	☐ Alzheimer's/Dementia	☐ Constipation	☐ Arthritis

LABORATORY DATA: _____

CURRENT MEDICINES: _____

_____

NUTRITION SCREEN:

How would you rate your diet/appetite ☐ Good ☐ Fair ☐ Poor
Do you have any chewing or swallowing difficulties? ☐ No ☐ Yes
Have you had any unintentional weight changes in the last six months? ☐ No ☐ Yes
Have you had nausea/vomiting/diarrhea for more than three days? ☐ No ☐ Yes
Are there any religion/cultural dietary needs that we may assist you with? ☐ No ☐ Yes
Do you take any vitamin/mineral/herbal supplements? ☐ No ☐ Yes
If yes, please specify type and amount per day. _____
Do you take any other food supplements? ☐ No ☐ Yes
If yes, please specify type and amount per day. _____
Do you have any food allergies? ☐ No ☐ Yes

FUNCTIONAL SCREEN:

Do you have any new or recent problems with routine daily activities? ☐ No ☐ Yes
Have you had any recent problems with speech, communication, memory or swallowing? ☐ No ☐ Yes
Resource list given? ☐

PAIN ASSESSMENT:

Are you having pain now or have you experienced pain in the recent past several weeks? ☐ No ☐ Yes
If you answered yes above, will your pain interfere with your visit today? ☐ No ☐ Yes
Can we assist you with your pain with a list of community resources? ☐ No ☐ Yes
Resource list given? ☐

EDUCATIONAL NEEDS ASSESSMENT:

Do you have any educational needs regarding your disease process, medication, medical care, or procedures? ☐ No ☐ Yes

What approach to learning best meets your needs?
☐ Reading ☐ Doing/Demonstration ☐ Listening/Observing ☐ Role Play
Are there any factors that may affect your ability to learn? ☐ No ☐ Yes

DIET HISTORY QUESTIONNAIRE:

Who usually does the grocery shopping for your household?

☐ Self ☐ Significant Other ☐ Both ☐ Other

Who usually prepares the food eaten at home?

☐ Self ☐ Significant Other ☐ Both ☐ Other

How is the food usually prepared at home?

☐ Fried ☐ Baked ☐ Broiled ☐ Micro-waved ☐ Other

How many times per week do you eat at:

Fast food restaurants (McDonalds / Burger King)? _____ Times per week

Cafeterias (school / work)? _____ Times per week

Family style restaurants (Friches, Bob Evans)? _____ Times per week

Fine dining? _____ Times per week

Do you use salt at the table? ☐ No ☐ Yes

Do you use salt in cooking? ☐ No ☐ Yes

Do you use salt substitute(s)? ☐ No ☐ Yes

If yes, please list type: _____

Do you use sugar at the table? ☐ No ☐ Yes

If yes, please list type: _____

Do you use sugar substitute(s)? ☐ No ☐ Yes

If yes, please list type: _____

WEIGHT HISTORY:

Highest weight at current height? _____ Age: _____

Lowest weight at current height? _____ Age: _____

Attempted weight loss? _____ Gain: _____

Have you ever been on a diet? ☐ No ☐ Yes

If yes, please describe: _____

Have you ever taken medication for weight loss or weight gain? ☐ No ☐ Yes

If yes, please describe: _____

What factors may prevent you from achieving your diet goals? _____

_____

_____

PHYSICAL ACTIVITY:

How would you describe your current activity level: ☐ Inactive ☐ Active ☐ Very Active

ANY OTHER PERTINENT INFORMATION YOU FEEL WOULD BE HELPFUL: ☐

_____

_____

_____

_____

_____

_____