

**Student Health Services
The Ohio State University
1875 Millikin Road
Columbus, OH 43210**

Last Name	First	MI
MRN		
(place patient label here)		

Patient Name

Please answer the following questions. Save your document and print a copy to bring to your first appointment with the dietitian.

GENERAL INFORMATION

Undergraduate ☐ Graduate ☐ What are you studying?

Have you ever seen a dietitian before? Yes ☐ No ☐ If yes, when?

What questions do you have for the dietitian?

Do you currently take any vitamins or supplements? Yes ☐ No ☐
If yes, please list:

Where do you live?
Residence halls ☐ Off campus - alone ☐ Off campus with roommates ☐
Off campus with family/spouse ☐

PHYSICAL ACTIVITY

Do you currently exercise? Yes ☐ No ☐

How frequently do you exercise aerobically? _____ days/week for _____ minutes/day

What do you do for aerobic activity?

How frequently do you strength train? _____ days/week for _____ minutes/day

What do you do for leisure activities?

Do you have any exercise limitations? Yes ☐ No ☐
If yes, please describe:

DIETARY HABITS

How would you rate your diet? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Has your appetite changed within the past month? Yes ☐ No ☐
If yes, please explain:

DIETARY HABITS, continued

Do you have any food allergies or food intolerances? Yes ☐ No ☐

If yes, please list:

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

If yes, what diets have you tried?

Are you currently following a special diet (e.g., low fat, low salt)? Yes ☐ No ☐

If yes, what diet are you on?

Have you ever purposefully restricted food intake and obtained what you or others felt was an extremely low or unhealthy weight? Yes ☐ No ☐

If yes, please explain:

Have you ever thrown up, used laxatives, fasted or exercised for long periods of time to lose weight? Yes ☐ No ☐

If yes, please explain:

Who prepares your meals?

Where do you eat your meals?

With whom do you eat your meals?

How often do you eat fast food or go to a restaurant?

0-1 times/month ☐ 2-3 times/month ☐ 1-2 times/week ☐
3-4 times/week ☐ 5+ times/week ☐

How often do you drink alcohol?

0-1 times/month ☐ 2-3 times/month ☐ 1-2 times/week ☐
3-4 times/week ☐ 5+ times/week ☐

When you do drink, on average, how many servings of alcohol do you drink in one sitting (1 serving = 12 oz beer, 5 oz wine, 1 oz liquor)? serving(s)

Thank you for completing this questionnaire.

Dietitian Comments _____

Dietitian Signature _____ Date _____