

# BERGEN

## GASTROENTEROLOGY • MEDICAL ASSOCIATES

### NUTRITION ASSESSMENT FORM

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: \_\_\_\_\_

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