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Dietitian History Questionnaire and Assessment

General Information:

Name: _____ Today's Date: _____

Occupation: _____ Full time Part time

Place of Employment: _____

Address: _____

Phone: _____ Phone #2: _____ Email: _____

Age: _____ Date of Birth: _____ Gender: _____

Reason for Appointment: _____

Primary Care Provider: _____

Address/Phone: _____

Therapist: _____

Address/Phone: _____

Education level: Grammar School High School College Graduate School

Marital Status: Single Married Divorced Separated Widowed

Number of Children: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Age: _____ Date of Birth: _____ Gender: _____

Medical History:

Height: _____ Current Weight: _____

Please indicate whether you or a family member have/had any of the following conditions:

Disease/Condition	Self	Family	Relationship	Treatment
Asthma	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Cardiovascular Disease	_____	_____	_____	_____

Diabetes	_____	_____	_____	_____
Drug Dependency	_____	_____	_____	_____
Eating Disorder	_____	_____	_____	_____
Food Allergies	_____	_____	_____	_____
Food Intolerances	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Heart Attack	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____
Intestinal Problems	_____	_____	_____	_____
Menstrual Problems	_____	_____	_____	_____
Mental Health Issues	_____	_____	_____	_____
Obesity	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____
Other	_____	_____	_____	_____

Are you currently being treated for any medical conditions? Yes No

If yes, please specify: _____

List any medications you are currently taking or have taken in the last year:

- | | |
|----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |

Are you currently taking any food or nutritional/herbal supplements? Yes No

If yes, please specify: _____

Have you ever been advised by your physician to follow a special diet? Yes No

If yes, please specify: _____

Are you currently following that diet? Yes No

If not, why? If yes, what changes have you made? _____

Do you drink alcohol? Yes No Number of drinks per week: _____

Do you smoke cigarettes? Yes No Amount per day: _____

How long have you smoked? _____ If you quit smoking, when? _____

Do you use drugs? Yes No Explain: _____

Menstrual History: (Female Patient):

Are you currently menstruating? Yes No Have never menstruated

At what age did you get your first period? _____

Date of last menstrual cycle: _____ Weight at that time: _____ pounds

Are your periods regular? ___ Yes ___ No

Are you taking birth control pills / estrogen pills? ___ Yes ___ No

Do you experience PMS? ___ Yes ___ No

If yes, what are your symptoms? _____

Weight/Dieting History:

Have you tried to lose weight before? ___ Yes ___ No

How many times? _____ Age of first attempt: _____ years

What did you do? _____

Why did you go on that diet? _____

Have you ever used any of the following for weight control? If yes, please explain.

Commercial diet programs ___ Yes ___ No _____

Liquid diets ___ Yes ___ No _____

Fad diets ___ Yes ___ No _____

Prescription diet pills ___ Yes ___ No _____

Over-the-counter diet pills ___ Yes ___ No _____

Laxatives ___ Yes ___ No _____

Diuretics ___ Yes ___ No _____

Ipecac syrup ___ Yes ___ No _____

Vomiting ___ Yes ___ No _____

Self-designed program ___ Yes ___ No _____

Other _____

Do you experience periods during which you eat uncontrollably? ___ Yes ___ No

If yes, how often? _____

At what age did this begin? _____ years

Is this followed by:

___ Vomiting Age began: _____ How often? _____

___ Laxative use Age began: _____ How often? _____

___ Excessive exercising Age began: _____ How often? _____

___ Self harm Age began: _____ How often? _____

___ Negative emotions Age began: _____ How often? _____

___ Other (explain) _____

Have you ever been diagnosed with an eating disorder? ___ Yes ___ No

If yes, please explain: _____

Are you currently or have you ever received treatment? ___ Yes ___ No

If yes, please explain: _____

Do you currently exercise for weight control? ___ Yes ___ No

Please explain: _____

Exercise History:

Do you exercise? ___ Yes ___ No

Please explain: _____

Do you have any physical conditions that limit your ability to exercise? Yes No
Please specify: _____

Family Weight History:

Are any members of your family overweight? Yes No

Please explain: _____

Are any members of your family underweight? Yes No

Please explain: _____

Does anyone in your family diet? Yes No

Please explain: _____

Did/Does anyone in your family have an eating disorder? Yes No

Please explain: _____

Does your family eat meals together? Yes No

What meals? _____

What is this like? _____

Eating Habits:

Do you skip meals? Yes No

How many days per week do you eat:

Breakfast: _____ Lunch: _____ Dinner: _____

Do you snack? Yes No

If so, when? _____

Do you buy or pack your lunches?

Buy # days per week: _____ Pack # days per week: _____

Do you eat out? Yes No

How many meals per week? _____

What restaurants do you usually choose?

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

Who usually prepares the food at home? _____

Do you know how to cook? Yes No

Who does the grocery shopping? _____

Do you read food labels? Yes No What do you look at on the label? _____

Do the nutrition facts influence your decision to eat the food? Yes No

Do you eat standing up? Yes No

Do you eat in the car? Yes No

Do you eat while watching TV? Yes No

Do you eat while reading or on the computer? Yes No

Do you eat with others? Yes No

Do you eat fast? Yes No

Do you eat when bored? Yes No

Do you eat when stressed? Yes No

Do you eat when you are anxious? Yes No

Do you eat when you are lonely? Yes No

Do you eat when you are hungry? Yes No

Do you eat when you are not hungry?

___ Yes ___ No

Do you avoid certain foods?

___ Yes ___ No

If yes, please specify: _____

What are your favorite foods? _____

Malnutrition Symptoms:

Do you now or have you ever experienced (for each checked, please add details to explain):

- ___ Irregular menstrual periods _____
- ___ Absent menstrual periods _____
- ___ Cold intolerance _____
- ___ Tingling sensation in hands or feet _____
- ___ Headaches _____
- ___ Lightheadedness/Dizziness _____
- ___ Fainting _____
- ___ Sleeping difficulties _____
- ___ Skin changes _____
- ___ Hair loss _____
- ___ Hair growth on face and/or chest _____
- ___ Chest pains _____
- ___ Rapid heart beat _____
- ___ Shortness of breath _____
- ___ Mood swings _____
- ___ Episodes of crying for "no reason" _____
- ___ Frequently thinking about food _____
- ___ Confusion _____
- ___ Difficulty concentrating _____
- ___ Anxiety, especially around food _____
- ___ Less social interaction with family _____
- ___ Frequently tired _____
- ___ Memory problems _____
- ___ Difficulty making decisions _____
- ___ Problems with teeth _____
- ___ Sore throat _____
- ___ Swollen parotid glands _____
- ___ Taste changes _____
- ___ Constipation _____
- ___ Diarrhea _____
- ___ Muscle pain _____
- ___ Joint pain _____
- ___ Obsessive-compulsive behaviors _____
- ___ Feelings of depression _____
- ___ Other (explain) _____

Goals/Expectations

Do you want to change your eating habits?

___ Yes ___ No

Why? _____

Did you have any expectations from coming to see the nutritionist today? ___ Yes ___ No

Please explain: _____

