Nutrition Consultation Preliminary Questionnaire

UNM Employee Wellness

Complete and bring this form to your appointment. Do not email it; email is not secure for personal health information.

Date: ______________ Birthdate: __________________

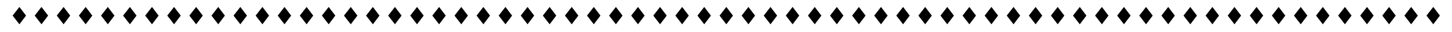
Name: ____ Gender: _________

Email: ____ Phone: ______________________________

Affiliation to UNM: ☐ UNM Faculty ☐ UNM Staff ☐ Other: ___________________________________

How did you hear about our services? ____

Reason for today's visit: ____



Medical History

Self-reported: Height: ____________ Weight: ___________ Desired Weight: ____________

Are you comfortable with your current weight? ☐ Yes ☐ No: why? _______________________________________

Have you ever had any of the following? *(Check all that apply)*

☐ Heart disease
☐ High blood pressure
☐ Stroke
☐ Obesity
☐ Thyroid problems
☐ Diabetes: specify type: ______________
☐ GERD/acid reflux
☐ Chronic diarrhea or constipation
☐ Sleep apnea
☐ Eating disorder
☐ Osteoporosis
☐ Cancer – specify type: ________________

List recent labs (if available): Date Taken: _______________

Total cholesterol: ________ HDL: ________ LDL: ________ Triglycerides: ________ Glucose/A1C: ________

Do you have a family history of any of the conditions listed above? If yes, list:

____

____

Are you taking any prescription medications now? ☐ Yes ☐ No

If yes, what are they, what are they for, and what is the dose? ____

____

____

Are you taking any vitamins, minerals, dietary supplements, or herbal supplements? ☐ Yes ☐ No

If yes, what are they? ____

____

Do you now or have you ever used tobacco? ☐ Yes ☐ No

If yes: Type: _________________ How long? _________ Quantity_____ /day Years since quitting: ______

DIET HISTORY

Do you have allergies or sensitivities to any food? ☐ Yes ☐ No

If yes, what are they? ______________________________

Who prepares the food/meals for you? ______________________________

How many times a day do you typically eat (including meals and snacks)? ______________________________

How many times a week do you get food from convenience stores/restaurants/carryout? Include breakfast, lunch, dinner between meal snacks and breaks like coffee.

____

How much do you drink of the following?

Water	________	oz/day	Beer	________	oz/week
Regular soda	________	oz/day	Wine	________	oz/week
Diet soda	________	oz/day	Hard liquor/spirits	________	oz/week
Caffeinated coffee or tea	________	oz/day			

Do you eat dairy products? ☐ Yes ☐ No What type? ☐ Whole ☐ 2% ☐ 1% ☐ skim/nonfat

Do you eat meat and poultry? ☐ Yes ☐ No If yes, how many times/week? ______________________________

Do you eat fish? ☐ Yes ☐ No If yes, how many times/week? ______________________________

Are you vegetarian? ☐ Yes ☐ No If yes, which type? ______________________________

PHYSICAL ACTIVITY

What do you do for physical activity/exercise now? ______________________________

____

____

How often do you exercise? ______________________________

____

How long per session? ______________________________

____