YourMD

Nutrition Survey

NAME _____ DATE _____

Please indicate which of the following you are taking/using:

- ☐ **Multivitamin**
- ☐ **Antioxidants**
- ☐ **Fish oils**
- ☐ Calcium
- ☐ Over-the-counter meds
- ☐ Diet pills
- ☐ Diuretics
- ☐ Drugs
- ☐ Alcohol, how often _____
- ☐ Caffeine
- ☐ Tobacco
- ☐ Sleep aids
- ☐ Salt
- ☐ Salt substitutes
- ☐ Cholesterol meds

Other vitamins: _____
_____

☐ Yes	☐ No	Do you have any known food allergies or food sensitivities?
		List:_____
☐ Yes	☐ No	Have you ever been diagnosed with heart disease or diabetes?
☐ Yes	☐ No	Do you have family history of heart disease or diabetes?
☐ Yes	☐ No	Have you ever been diagnosed with Metabolic Syndrome?
☐ Yes	☐ No	Are you overweight?
☐ Yes	☐ No	Any recent weight gain/loss? How much? _____ Duration of time: _____
☐ Yes	☐ No	Do you have a weight loss goal? How much? ____ Duration of time:_____
☐ Yes	☐ No	Do you currently exercise?
		Please describe type of exercise/duration/frequency: _____
☐ Yes	☐ No	Are you satisfied with your current fitness level?
☐ Yes	☐ No	Have you had % of body fat calculated? Value: _____
☐ Yes	☐ No	Do you have any concerns about your energy level? _____
☐ Yes	☐ No	Do you have any concerns about your sleep habits? _____
☐ Yes	☐ No	Do you have any elimination problems (including urination or constipation)?
☐ Yes	☐ No	Do you have any digestion problems?

Describe your eating habits. Circle all that apply:

- Eat 3 meals/day
- Snack throughout the day
- Often feel hungry
- Eating disorder
- Heart burn
- Junk food
- Purge-eating (induce vomit after meal)
- Frequently skip meals
- Eat until you feel stuffed or sick
- Binge-eating
- Acid reflux
- Fast food
- Stress-Eating
- Frequent guilt after meals

Describe you fluid intake. How much do you consume daily:
Water? _____ Soda? _____ Other beverages? _____
Rate your stress on a 1-10 scale: [low] 1 2 3 4 5 6 7 8 9 10 [high]
What do you do to manage your stress: _____

Dr. Init_____