UCF Student Health Services Nutrition History

Be advised there is a $30 **No Show fee** or failure to cancel within 24 hours

Personalized recommendations will not be provided if Nutrition History and Food Logs are not completed.

Date:_______________________

First Name

Last Name

Name: _____________________________________ PID#: _______________________

Sex: ☐Female ☐Male Date of birth: ___________ Age: _____ Height: _______ Weight: _________

Living Situation: ☐ Dorm ☐ On-Campus Apartment ☐ Off-Campus Apartment ☐ Home

☐ Alone ☐ Roommates ☐ Family

Year: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Grad Student Major:___________________

Have you seen a dietitian/nutritionist before: ☐Yes ☐No If so, When and Why?_________________________

Why do you want to see the dietitian? Please check all your nutrition-related concerns:

☐ Anemia ☐ Disordered Eating: *Anorexia, Bulimia, Binge* Eating*,* Emotional eating

☐ Diabetes ☐ Hypoglycemia ☐ High cholesterol ☐ High triglycerides

☐ Celiac Disease ☐ Irritable bowel syndrome ☐ Heartburn ☐ High blood pressure

☐ Healthy eating ☐ Vegetarian eating ☐ Sports Nutrition, exercise, and weightlifting

☐ Food Intolerance ☐ Supplements ☐ Want to lose weight ☐ Want to gain weight

☐ Other: _____________________________________

Medical/Health History:

Are you currently being treated for a medical condition: ____

____

Are you taking any prescribed medications? ☐Yes ☐No

Medications	Amount	How Often	Why Are You Taking It?
_______________________________	_________	__________	_______________________
_______________________________	_________	__________	_______________________

Are you taking any Vitamins, Minerals, Supplements, Herbs, Botanicals, Sports Nutrition Supplements

Supplement	Amount	How Often	Why are you taking it?
___________________________	______	_________	_________________

Do you have any food allergies or intolerances? ☐ Yes ☐ No ☐ Not sure

Food	What Happens When You Eat This Food
______________________________	____
______________________________	____

Do you smoke? ☐Cigarettes ☐ Cigars ☐ Hooka ☐ E-cigarettes ☐ Marijuana ☐ I don't smoke

How many do you smoke per day? _____ per day ______per week

In a typical week, how many days do you drink alcohol? I drink ___ days per week.

When I drink, I usually have ___ drinks. (1 drink+1.5 ounces of 80 proof liquor, 5 oz. of wine, or 12 oz. beer)

If you consume alcohol, do you restrict calories before or after drinking?

☐Yes ☐ No ☐ Sometimes

Weight History:

Usual weight: ______ Weight when graduated High School: ______ Desired weight range: ______

Do you weigh yourself? ☐ Yes ☐ No

How often do you weigh yourself? ____

Have you had any recent weight gain or loss? ☐ Yes ☐ No

How much over how long? ____

What methods have you used to lose weight in the past?

Dieting Calorie counting diet pills laxatives diuretics exercise

How successful were they?____

Do you follow a special diet due to prescription, personal or religious reasons? Yes or No

If yes, What type of diet? _________________ Who prescribed or suggested it? _______________________

Have you ever had a medically diagnosed eating disorder? ☐ Yes ☐ No ☐ Not sure

If yes, please explain: ____

Have you seen a specialist for anorexia, bulimia, and/or binge eating? Yes_____ No______

Yes, I saw specialist ______ times in last _______ years.

When was the last time you binged and/or purged? ____

What foods do you usually binge on? ____

How much do you eat during a binge? ____

What do you do to purge? ☐ Vomiting ☐ Laxatives ☐ Exercise How Often? _______________________

Eating Habits:

What would you like to change about your eating? ____

____

How would you generally describe your eating habits? ☐ Good ☐ Fair ☐ Poor

Does your food intake or weight feel out of control? ☐ Yes ☐ No

How would you rate your appetite recently? ☐ Hearty ☐ Normal ☐ Moderate ☐ Poor

Which of the following best describes the way you eat?

- ☐ I keep track of calories eaten at each meal/ I know my exact calorie intake for the day.
- ☐ I have a general idea about the number of calories eaten at each meal/ I know roughly how many calories I consume in a day.
- ☐ I do not keep track of calories eaten at meals/ I am not sure how many calories I am consuming in a day.

Please rate the following statements:	Strongly agree		Neutral		Strongly disagree
I would be happier if I lost weight	1	2	3	4	5
Overweight people could lose weight if they were more disciplined	1	2	3	4	5
Thin people are happier than overweight people	1	2	3	4	5
Thin people are more attractive than overweight people	1	2	3	4	5
Thin people are healthier than overweight people	1	2	3	4	5
The media exaggerates the dangers of being overweight	1	2	3	4	5
The media places too much emphasis on being thin	1	2	3	4	5

Do you avoid any of the following foods? (Check all that apply)

☐ Red meat	☐ Fruits	☐ Dairy (milk, cheese, yogurt)	☐ Eggs
☐ Poultry (chicken, turkey)	☐ Vegetables	☐ Snack foods (chips, crackers)	☐ Fast food
☐ Fish, seafood, shellfish	☐ Breads	☐ Sweets (candy, desserts)	☐ Fried food
☐ Pork	☐ Grains (pasta, rice)	☐ Fats/oils (mayo, dressing, butter)	☐ Alcohol

Foods you especially like:

____

Foods you especially dislike:

____

Are you vegetarian? ☐ Yes ☐ No I *don't* eat: ☐eggs ☐ milk ☐ chicken ☐ fish ☐ honey ☐ pork ☐ ____________

Are you vegan? ☐ Yes ☐ No

How often do you eat fewer than 3 times a day? ☐ Daily ☐ Almost Daily ☐ Weekly ☐ Rarely ☐ Never

What meal do you skip most often? ____

How many meals do you eat per week at:

___ Home ___ Dining Hall ___ Meal plan ___ Greek House

___ Fast-Food Chain ___ Restaurant ___ Other (Please explain) ____________________________________

What type of food do you usually eat? (Check all that apply)

- ☐ Prepared from scratch
- ☐ Easy to prepare foods (macaroni & cheese, frozen dinners, soup, spaghetti, etc.)
- ☐ Ready to eat foods (take out, Supermarket, convenience store)

List the 3 most common restaurants or fast food places you frequent?

1. ____
2. ____
3. ____

How many snacks do you eat per day? ____

Please consider the following questions or statements:

It's hard for me to stop eating when full.

☐ Often ☐ Sometimes ☐ Rarely ☐ Never

I go through long periods of time without eating.

☐ Often ☐Sometimes ☐ Rarely ☐ Never

I eat to avoid dealing with problems.

☐ Often ☐ Sometimes ☐ Rarely ☐Never

I have determined that there are "safe" foods that are okay for me to eat and "bad" foods that I refuse to eat.

☐Yes ☐ No

Do you have any personal concerns/problems with the following:

Appetite	Bleeding Gums	Bruising	Chewing or swallowing
Fatigue	Headaches	Difficulty sleeping	Mood swings
Diarrhea	Constipation	Indigestion	Acid Reflux
Bloating	Edema	Hemorrhoids	Urinary Tract Infections
Body Image	Menstrual difficulties	Yeast infections	

Who does the grocery shopping? ____

How comfortable are you grocery shopping, meal planning and making food choices? __________________________

What is the most difficult time of day or most difficult lifestyle situation for you to make healthy choices? ___________

____

Where do you get most of your nutrition information? ____

How do you cope with stress? ____

Physical Activity:
Are you currently physically active? ☐ Y ☐ N
If yes, How often: ______ times per week
How long: _____ minutes per session
Type of activities: ____

Please rate the average intensity of your workouts: (Circle one)
Light (walking slowly, sitting, standing)
Moderate (walking briskly, heavy cleaning, light bicycling)
Vigorous (hiking, running, fast bicycling, most team sports, weight lifting)

Have you ever exercised to compensate for eating too much? ☐ Yes ☐ No

Barriers to exercise:
☐ Lack of time ☐ Illness/Injury ☐ Cost ☐ Lack of motivation ☐ Lack of energy ☐ Do not feel comfortable

Nutrition Goals:
Anything else I should know? ____

What do you hope I can do for you? ____

Do you have any specific goals or areas of your eating habits that you would like to work on? ________________
____

List 3 goals you now hope to achieve while working with the nutrition intern/dietitian.
1. ____
2. ____
3. ____

How important is it to you to make changes in your nutrition habits? (Please circle)
1 2 3 4 5 6 7 8 9 10
Very Important Unimportant

How confident are you in your ability to improve your nutrition habits? (Please circle)
1 2 3 4 5 6 7 8 9 10
Very Confident Not Confident

What barriers, if any, stand in the way of you achieving your nutritional goals (Check all that apply)?
☐Time ☐ Hunger ☐ Stress ☐ Influence of others ☐ Money ☐ Don't like to exercise
☐ Not sure what to eat ☐ Not a priority ☐ Lack of motivation ☐ Other(s), list: ___________________

1 Day Food Record (Weekday)

Please fill out the table below to the best of your ability. Aim at being accurate and descriptive with types and amounts of food eaten. List all beverages, including water and alcoholic beverages drunk throughout the day. An example is provided for you.

Time	Food Item	Amount Eaten	Type or brand	How Prepared	Location
Example: 8:00 AM	Egg Whites Cheese Toast Margarine OJ	3 1 slice 2slices 1 tsp 1 c	N/A 2% Reduced fa Whole Wheat I can't believe it's not butter Regular OJ	Pan fried Toasted	Home

Dietitian's Notes:

Revised 6/2015

1 Day Food Record (Weekday)

Please fill out the table below to the best of your ability. Aim at being accurate and descriptive with types and amounts of food eaten. List all beverages, including water and alcoholic beverages drunk throughout the day. An example is provided for you.

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Dietitian's Notes:

Revised 6/2015

1 Day Food Record (Weekend)

Please fill out the table below to the best of your ability. Aim at being accurate and descriptive with types and amounts of food eaten. List all beverages, including water and alcoholic beverages drunk throughout the day. An example is provided for you.

Time	Food Item	Amount Eaten	Type or brand	How Prepared	Location
Example: 8:00 AM	Egg Whites Cheese Toast Margarine OJ	3 1 slice 2slices 1 tsp 1 c	N/A 2% Reduced fa Whole Wheat I can't believe it's not butter Regular OJ	Pan fried Toasted	Home

Dietitian's Notes:

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