

DIET HISTORY FORM

Name _____ Date: _____

Height _____ Weight _____ Desired Weight _____ Age _____

Food Likes _____

Food Dislikes _____

Known Food Allergies _____

Medications (please **circle** those you are currently taking):

Antacids	Diuretics	Muscle Relaxers	Insulin
Anti-inflammatory	Chemotherapy	Antibiotics	Other
Cholesterol	Antidepressants	Hormone Therapy	
Laxatives	Oral Contraceptives	Heart Medications	

How many meals do you eat each day? 1 2 3 4

What is the average size of your meal? Small Moderate Large

Do you tend to snack through the day? Yes No

Estimate the % of your normal daily diet: _____% protein _____% carbs _____% fat

Do you drink beverages with caffeine?	Yes	No
Do you drink diet drinks?	Yes	No
Do you drink beverages with alcohol?	Yes	No
If yes, how many per week?	_____	Wine
	_____	Beer
	_____	Hard Alcohol

Do you consume healthy fats? Omega 3 Fish Oil Avocados Olive Oil
Flaxseed Oil

Do you eat sweets on a regular basis? Yes No Type: _____

Do you consume dairy products? Yes No Type: _____

How is your daily water intake? Glasses per day _____

What vitamins and mineral supplements are you taking?

What diet programs have you been on in the past year? (Circle all that apply)

Low Fat	Weight Watchers	the Zone
Jenny Craig	Low Salt	Low Cholesterol
Low Calorie	Atkin's	Low Carbohydrates

COMMENTS:
