

MEDICAL NUTRITION THERAPY QUESTIONNAIRE

Name _____ **Date of Birth** _____

1. When were you first told that you have diabetes or pre-diabetes? _____
2. Have you had previous instruction on diet? Yes No
When was this done? _____
3. Have you been told to follow any other diet restrictions? Yes No
If yes, please check which restrictions:
low calorie low cholesterol low salt/sodium low protein
low fat high fiber other _____
4. Has your weight changed in the past year? Yes No
If yes, describe the change. _____
5. Please circle the highest level of school completed.
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+
6. Occupation _____
7. What are your usual work hours? _____
8. Do you drink alcohol? beer wine liquor
9. Do you take vitamins or any other nutrition supplement? Yes No
If yes, please list: _____
10. What eating concerns do you have?

11. What would you like to know more about?
 weight loss exercise eating out
 label reading alcohol use sweeteners
 other _____
12. What do you hope to accomplish or gain from this appointment?
 improve blood glucose get more information
 improve eating habits start exercising
 achieve a reasonable body weight lower cholesterol /triglycerides
 other _____