Reading Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

Outpatient Nutrition Services
420 S. Fifth Ave • DOB Suite 310
West Reading, PA 19611

Please complete the following questionnaire:

1. Occupation: _____ Work Hours:_____

2. Height: _____ Weight: _____ Has your weight changed recently? Yes _____ No _____
If yes, please explain:_____

3. What weight are you most comfortable with? _____

4. Are you following any special diet now? Yes _____ No _____ If yes, please explain: _____

5. Were you ever instructed on a special diet? Yes _____ No _____ If yes, please explain: _____

6. Who prepares your meals at home? _____ Who does the grocery shopping? _____

7. How many people are in your household? _____ 8. How many meals do you eat out each week?_____

9. List the beverages you drink and amount per day.

	Milk	Juice	Soda	Coffee	Tea	Water	Alcohol	Other
Type:								
Amount:								

10. Do you have any food allergies? Yes _____ No _____ If yes, please list:_____

11. Do you avoid any foods for health or religious reasons? Yes _____ No _____
If yes, please explain:_____

12. Do you have any strong food dislikes? Yes _____ No _____
If yes, please explain:_____

13. Do you have any problems chewing or swallowing food? Yes _____ No _____
If yes, please explain:_____

14. Do you use salt with your food? Yes _____ No _____ Add in cooking? Yes _____ No _____

15. Do you have pain interfering with eating or drinking? Yes _____ No _____
If yes, please explain:_____

16. Are you frequently bothered by: Nausea_____ Vomiting_____ Heartburn_____ Constipation_____ Diarrhea_____

Patient Name:

MRN:

Date of Birth:

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17. Do you have any physical condition that affects your ability to exercise? Yes _____ No _____
If yes, please explain:_____

18. Do you participate in any exercise or physical activity program? Yes _____ No _____
If yes, how often:_____ What type?_____

19. What would you like to learn today and what are you nutrition concerns? _____
_____

20. How do you like to learn? (brochures, discussion, examples, etc.) _____

21. Please check any medical problems in **your family**.

Cancer		High blood pressure	
High Cholesterol		Stroke	
Diabetes		High Triglycerides	
Heart Attack		Unknown	

22. If you are **NOT in** the Tower Health network, please check all of the medical problems that **you** have.

Anemia		Diverticular Disease		Irritable Bowel Disease	
Anorexia/Bulimia/Eating Disorder		Drug/Alcohol Dependency		Kidney Disease	
Arthritis		Edema/Fluid Retention		Lactose Intolerance	
Asthma/Pulmonary Problem		Fibromyalgia		Liver Disorder	
Cancer		Gestational Diabetes		Overweight	
Celiac Disease		Heart Attack		PCOS	
High Cholesterol/Triglyceride		Heart Failure		Sleep Apnea	
Constipation		Hiatal Hernia		Stomach Problems	
Crohn's Disease		High Blood Pressure		Stroke	
Depression		HIV/AIDS		Thyroid Disease	
Diabetes/Prediabetes		Insulin Resistance		Other	

23. Please check any surgeries you have had:

Colon/Bowel Surgery		Knee or Hip Replacement		Heart Surgery	
Gastric Bypass		Stomach Surgery		Other	

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24. If you are **not** in the Tower Health network, please list all medications you are taking.

Medication	Dose	Frequency

25. Please list all vitamin, mineral, herbal supplements and over the counter items that you are taking.

Medication	Dose	Frequency

26. If your providers are **not** in the Tower Health network, please send a report of my Medical Nutrition Therapy session(s) to the providers listed:

_____ _____

Provider Name Practice Name

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Please record everything that you eat and drink for at least three days before your appointment. List how much food was eaten (ounces, cups, tablespoons, teaspoons), how the food was prepared and any sauces or condiments that were used.
Please list any physical activity or exercise you did. Record amount of time spent doing the activity.

	Day 1	Day 2	Day 3
Breakfast			
Snack			
Lunch			
Snack			
Supper			
Snack			
Physical Activity			
Comments			

Patient Name:

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