Name: ______________________________ Date: ________________

Basic Nutrition Questionnaire

Have you ever been told you have High Cholesterol or Triglycerides? Yes No

Have you ever been diagnosed with high blood pressure? Yes No

Have you ever been diagnosed as diabetic? Yes No

Have you been diagnosed as Pre-Diabetic or Metabolic Syndrome? Yes No

How many days a week do you skip a meal? (3 meals/day) __________

How many “fast food”, “refined food”, or “pre-prepared” meals do you eat per week?

(None) (1-3) (4-6) (7+)

How many servings of fruit do you eat a day? (0-1) (2-3) (4-5)

How many servings of vegetables do you eat a day? (0-1) (2-3) (4-5)

Do you regularly drink one or more per day of the following: (circle all that apply)

Soda Diet Soda Coffee Juice Milk Alcohol

How many servings of refined sugar do you eat per day? (candy, cookies, cake, etc.)

(0-1) (2-3) (4-5)

Please list all nutritional supplements/vitamins you take regularly.

Supplement Name/Type	Frequency	Brand or where purchased
____________________	__________	__________________
____________________	__________	__________________
____________________	__________	__________________
____________________	__________	__________________
____________________	__________	__________________