UCF Student Health Services Nutrition History

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

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 Gender Identity (optional) _____

Date of birth: _____ Age: _____ Height: _____ Weight: _____

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

Living Situation: ☐ Dorm ☐ On-Campus Apartment ☐ Off-Campus Apartment ☐ Alone ☐ Roommates ☐ Home ☐ Family

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

Reason for this nutrition visit: Please check **all** your nutrition-related concerns:

☐ Anemia/Low energy	☐ Healthy eating advice	☐ Irritable bowel syndrome	☐ Sports Nutrition
☐ Celiac Disease	☐ Heartburn	☐ Crohn's/Colitis/Other GI issues	☐ Supplements
☐ Diabetes	☐ High blood pressure	☐ Nausea/ Vomiting	☐ Diarrhea/Constipation
☐ Hypoglycemia	☐ Lose weight	☐ Gain weight	☐ Vegetarian/Vegan
☐ Food Allergies/Intolerance	☐ High cholesterol/Triglycerides		
☐ Disordered Eating: *Anorexia, Bulimia, Binge Eating, Emotional Eating*		☐ Other: _____	

Medical/Health History

Are you currently being treated for any medical issues: _____

Any family medical history? Please specify _____

Which of the following best describes your family as a group?

☐ My family is not overweight or obese ☐ Some members of my family are overweight or obese

☐ Most members of my family are overweight or obese ☐ I am not sure.

Are you taking any prescribed medications? ☐Yes ☐ No

Medications	Amount	How Often	Why Are You Taking It?
_____	_____	_____	_____
_____	_____	_____	_____

Are you using Vitamins, Minerals, Supplements, Herbs, Botanicals, Sports Nutrition Supplements, Diet/Weight loss pills?

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 have any personal concerns/problems with the following?

Abnormal lab values	Body Image	Dark skin patches	Fainting Spells	Nausea
Acne	Bruising	Depression	Hair loss	Poor memory/concentration
Acid Reflux	Chewing or swallowing	Diarrhea	Headaches	Restlessness
Appetite	Cold Intolerance	Difficulty sleeping	Hemorrhoids	Stomach aches
Anger	Compulsive Eating	Dizziness	Hypoglycemia	Underweight
Anxiety	Confusion	Dry Skin	Indigestion	Urinary Tract Infections
Bleeding Gums	Constipation	Edema	Menstrual Difficulties	Vomiting
Bloating	Cravings	Fatigue	Mood Swings	Yeast infections

Lifestyle

Physical Activity: Are you currently physically active? ☐ Y ☐ N

If yes, How often: _____ times per week How long: _____ minutes per session

Type of activities: ☐ Stretching/Yoga ☐ Cardio/Aerobics ☐ Strength-training/Weight lifting ☐ Sports/Leisure ☐ Other_____

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

Stress: I deal with stress by…_____

Drinking: How often do you drink alcohol? ☐ 0-1 times/mo ☐ 2-3 times/mo ☐ 1-2 times/wk ☐ 3-4 times/wk ☐ 5+ times/wk

How many drinks, if you drink? (1 drink+1.5 ounces of 80 proof liquor, 5 oz. of wine, or 12 oz. beer)

☐ Do not drink ☐ 1-2 drinks ☐ 3-5 drinks ☐ 6-8 drinks ☐ 9 or more

What types of alcohol do you consume?

☐ Beer ☐ Wine ☐ Liquor ☐ Other

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

□Yes □ No □ Sometimes

Smoking: Do you smoke? ☐ Yes ☐ No

What do you use? □ Cigarettes □ Cigars □ Hookah □ E-cigarettes □ Marijuana □ I don't smoke

How much do you smoke? _____ per day_____per week Are you planning to quit? □Yes □No

Weight History

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

Lowest weight: _____ age _____ Highest weight: _____ age _____

Do you weigh yourself? ☐ Yes ☐ No

How often do you weigh yourself? □ More than once a day □ Daily □ Almost Daily □Weekly □ Rarely □ Never

Have you had any recent weight changes? ☐ Gain or ☐ Loss?

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? _____

Are you on a special diet due to prescription, personal or religious reasons? ☐ Yes ☐ No

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

Have you ever been 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

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? _____

How do you to purge? ☐ Vomiting ☐ Laxatives ☐ Exercise How Often? _____

Eating Patterns

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

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

Do you ever eat large amounts of food while feeling 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 eat 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.

Are you vegetarian? □ Yes □ No Are you vegan? □ Yes □ No

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

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

Foods you especially like: _____

Foods you especially dislike: _____

Do you skip meals? □ Daily □ Almost Daily □ Weekly □ Rarely □ Never

If you skip, how many meals do you skip per day? □ 0 □ 1 □ 2 □ 3

What meal do you skip most often? _____

Where do you eat your meals? Please specify how many meals per week at each location, for a total of 21 meals a week.

Home____ Fast-Food Chain____ Restaurant____

On Campus: Dining Hall____ Meal plan____ Greek House____ Other____ (Please explain) _____

With whom do you eat your meals? _____

On average, how long does it take you to eat a meal? _____

What type of food do you usually eat at home, apartment or dorm? (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)

How often do you eat out? □ 0-1 times/mo □ 2-3 times/mo □ 1-2 times/wk □ 3-4 times/wk □ 5+ times/wk

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

1. _____
2. _____
3. _____

How many snacks do you eat per day? □ 0-1 □ 2-3 □ 3-4 □ 4-5 □ 5+

What kind of snacks do you eat? _____

What do you drink on a typical day? When applicable, add the approximate amount consumed per day.

☐ Reg. soda _____	☐ Diet soda _____	☐ Reg. coffee _____	☐ Decaf. coffee _____
☐ Tea _____	☐ Decaf Tea _____	☐ Protein drinks _____	☐ Energy drinks _____
☐ 100% fruit juice _____	☐ Fruit drink/punch _____	☐ Plain water _____	☐ Flavored water_____
☐ Milk _____	☐ Milk Beverage (Almond, Soy, Coconut) _____		

☐Other (please explain) _____

Nutrition Self-Assessment

Please consider the following questions or statements:

I often:	Often	Sometimes	Rarely	Never
eat when bored/depressed/lonely/happy/anxious/nervous/upset/angry/stressed				
go through long periods of time without eating				
eat to avoid dealing with problems				
eat at various places in my home				
eat while doing other activities like watching TV, studying or reading				
eat all the food on my plate, even when I'm full				
eat quickly				
eat while driving				
eat in secret				
reward myself with food				
eat when I'm not hungry, but the food looks and smells good				
eat late at night				
overeat at parties, holidays, travelling or special occasions				
eat more around certain people or activities				
eat out of vending machines				
am comfortable grocery shopping				
shop for food hungry				
do not have enough money for food				
have gone hungry, because I do not have enough food				
am comfortable preparing and cooking food				
am comfortable measuring and recording food intake				
go on crash or fad diets				
I check with myself to see if I'm hungry and how hungry I am before eating				

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

Please list those foods "safe" or "bad" _____

Who grocery shops, meal plans and cooks' meals if you are not comfortable? _____

When 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? _____

Nutrition Goals and Readiness to Change

What are your goals for working with the dietitian?

1. _____
2. _____
3. _____

What are your expectations for nutrition counseling? _____

What would you like change about how you eat? _____

Why would you like to make changes now? _____

What benefits do you see from making this change? _____

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

Unimportant Very Important

How confident are you in your ability to improve your nutrition habits? (Please circle)

1 2 3 4 5 6 7 8 9 10

Not Confident Very 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: _____

Please indicate any changes you have made prior to meeting with the dietitian? _____

Anything else I should know? _____

Would you like to learn about our monthly, free cooking classes? ☐ Yes ☐ No

If yes, please provide your email address, so we can contact you with details about the next class _____

Food Record

Please record anything you eat and drink for **2 Weekdays** and **1 Weekend day**. Choose typical days – not a sick day or a day you ate or did something out of the ordinary. Record types and amounts of food eaten. List all beverages, including water and alcoholic beverages. If unsure of the amounts, it is better to overestimate, as most people underestimate how much they eat. Be as SPECIFIC, ACCURATE and DESCRIPTIVE as possible. Complete this form to the best of your ability. An example is provided for you.

Day of the Week:				**Wake Up Time:**			**Bedtime:**	
Time	**Place**	**Food**	**How much Eaten**	**Type or Brand**	**How Prepared**	**Activities while eating**	**Hunger level**	**Thoughts, feelings**
Example: *8:00 AM*	*Home*	*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*	*Watching TV, standing in the kitchen*	*4*	*Tired, rushed, stressed*
Breakfast								
Lunch								
Dinner								

Hunger level: 5 = very hungry 1 = not hungry at all

Dietitian's Notes:

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