

## Diet and Medical Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

**Please complete the questionnaire and fax it to 713-798-6409. A cover sheet is not necessary. This questionnaire contains information that will help us plan your diet. The information you provide will be kept confidential.**

### Food Preferences

1. Are you allergic or sensitive to any foods?  
 No     Yes, please specify \_\_\_\_\_
2. Are there other foods that you do not like or do not eat for religious reasons or other reasons?  
 No     Yes, please specify \_\_\_\_\_
3. Do you take vitamins, minerals, herbs, or use dietary supplements?  
 No     Yes, please specify \_\_\_\_\_

### Medical

4. Do you currently have or have you had the following? Check all that apply. If you take medication to control it, specify the name of medication.

- |   |                                |
|---|--------------------------------|
| <input type="checkbox"/> Elevated cholesterol                     | Medication to control it _____ |
| <input type="checkbox"/> Elevated triglyceride level              | Medication to control it _____ |
| <input type="checkbox"/> High blood pressure                      | Medication to control it _____ |
| <input type="checkbox"/> Diabetes type 1                          | Medication to control it _____ |
| <input type="checkbox"/> Diabetes type 2                          | Medication to control it _____ |
| <input type="checkbox"/> Impaired fasting glucose or pre-diabetes | Medication to control it _____ |
| <input type="checkbox"/> Heart attack                             | Medication to control it _____ |

5. Are you under a physician's care for any condition other than those mentioned above?  
 No     Yes, please specify \_\_\_\_\_

6. If you know the following laboratory results, please provide. If you were taking medication to control it, at the time of the blood test, please provide the name of medication.

Total cholesterol	_____ mg/dL	Date _____	Medication _____
Triglyceride	_____ mg/dL	Date _____	Medication _____
HDL "good" cholesterol	_____ mg/dL	Date _____	Medication _____
LDL "bad" cholesterol	_____ mg/dL	Date _____	Medication _____
Fasting blood glucose	_____ mg/dL	Date _____	Medication _____

7. Do you use a special margarine or other food to lower your cholesterol?  
 No  Yes, please specify \_\_\_\_\_

### Family History

8. Do you have a family history of the following? This includes your grandfather, grandmother, mother, father, brother, and sister. Check all that apply.

- Coronary heart disease with symptoms before age 60  
 Heart attack before age 60  
 Stroke before age 60  
 High blood pressure  
 Diabetes  
 High cholesterol  
 High triglycerides

### Tobacco Use

9. What best describes your use of cigarettes, pipes, and cigars?  
 Never smoked  Former smoker  Smoker

10. Do you use chewing tobacco or snuff?  
 No  Yes

### Exercise

11. Do you exercise regularly?  No  Yes  
Please describe your level of exercise or physical activity:

### Eating Style

12. Who usually does the grocery shopping where you live?  
 I do  
 Someone else does  
 It is shared among several people and me

13. Who usually prepares meals or snacks at home?  
 I do  
 Someone else  
 It is shared among several people and me

14. Is anyone in your home on a special diet?  
 No  Yes, please specify \_\_\_\_\_

15. When you eat meals or snacks at home, which of the following do you do most often? Check all that apply.

- Cook with recipes  
 Cook without recipes  
 Use convenience foods such as spaghetti sauces and rice mixes  
 Prepare frozen meals

16. How many times a week do you eat breakfast, lunch, or dinner in a RESTAURANT or FAST FOOD PLACE? Include all food prepared away from home, such as take-out food and home-delivered food and ready-to-eat or deli food to take home. Do not include brown bag meals prepared at home.

- Never eat out  
 1-3 times per week  
 4-6 times per week  
 7 or more times

### Hunger

17. How hungry do you usually feel BEFORE you eat meals or snacks?

MEALS

- Do not eat meals
- Not at all hungry
- A little hungry
- Neither hungry or full
- Moderately hungry
- As hungry as I have ever felt

SNACKS

- Do not eat snacks
- Not at all hungry
- A little hungry
- Neither hungry or full
- Moderately hungry
- As hungry as I have ever felt

18. How full do you usually feel AFTER you eat meals or snacks?

MEALS

- Do not eat meals
- Not at all hungry
- A little hungry
- Neither hungry or full
- Moderately hungry
- As hungry as I have ever felt

SNACKS

- Do not eat snacks
- Not at all hungry
- A little hungry
- Neither hungry or full
- Moderately hungry
- As hungry as I have ever felt

### Food Frequency

19. How often do you eat HIGH FAT MEATS such as marbled or untrimmed beef, pork, or lamb, regular hamburger meat, poultry with skin, bacon, sausage, hot dogs, and bologna?

- Daily
- 1 to 6 times per week
- 3 times per month or less
- Seldom or never

20. How often do you eat HIGH FAT DAIRY PRODUCTS such as whole or 2% milk, regular cheese, cream cheese, sour cream, or cottage cheese? Do not include ice cream and yogurt.

- Daily
- 1 to 6 times per week
- 3 times per month or less
- Seldom or never

21. How many WHOLE EGGS or EGG YOLKS do you eat a week? \_\_\_\_\_

22. How often do you eat FRIED FOODS such as French fries, fried meat, fried poultry, fried fish, potato or corn chips, fried vegetables, or fried cheese?

- Daily
- 1 to 6 times per week
- 3 times per month or less
- Seldom or never

23. How often do you use BUTTER or STICK MARGARINE with your food?

- Daily
- 1 to 6 times per week
- 3 times per month or less
- Seldom or never

24. How often do you eat HIGH-FAT BAKED FOODS such as biscuits, cornbread, croissants, waffles, or pancakes? Do not include sweet baked foods such as muffins and cookies.

- Daily
- 1 to 6 times per week
- 3 times per month or less
- Seldom or never

25. How often do you eat HIGH-FAT CONVENIENCE FOODS such as regular frozen dinners, entrees, or frozen pizza?

- Daily
- 1 to 6 times per week
- 3 times per month or less
- Seldom or never

26. How often do you eat HIGH-FAT SNACKS that are not sweet such as popcorn, high-fat crackers, and snack mixes?

- Daily
- 1 to 6 times per week
- 3 times per month or less
- Seldom or never

27. How often do you eat HIGH-FAT, HIGH SUGARED FOODS such as ice cream, puddings, cakes, muffins, cookies, pies, doughnuts, or chocolate candy?

- Daily
- 1 to 6 times per week
- 3 times per month or less
- Seldom or never

28. How often do you eat HIGH-SUGAR FOODS that are low-fat or fat-free such as desserts, cookies, frozen yogurt, regular soft drinks, and hard candy?

- Daily
- 1 to 6 times per week
- 3 times per month or less
- Seldom or never

29. How much alcohol do you drink? One drink is a can of beer; a shot of "hard liquor"; or 5 fl oz (an average glass) of wine.

- I don't drink alcoholic beverages
- 3 or less drinks per month
- 1 to 6 drinks per week
- 7 to 14 drinks per week
- 15 to 35 drinks per week
- More than 35 drinks per week

**THANK YOU for completing the questionnaire. Please fax to 713-798-6409.**