

# IOWA DIABETES & ENDOCRINOLOGY CENTER

## NUTRITION ASSESSMENT

Name: _____	Date of Birth: _____	Date: _____
	Yes   No	<i>If yes, please describe</i>
Do you follow a special meal plan now?		
Do you currently follow or have you ever followed:	Yes   No	<i>If yes, please describe</i>
Exchange meal plan		
Counted carbohydrates		
Counted calories		
Fat grams		
Weight Watchers		
Other diet:		
Do you have any food allergies or intolerances?		
<i>If yes, please describe:</i>		
Do you skip meals?		
Do moods/stress affect your eating?		
<i>If yes, please describe:</i>		
Do you eat meals/snacks at regular times every day?		
Who shops for your food? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other:		
Who prepares your meals? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other:		
How many times per week do you eat out or carry food in?		

Please write the foods and beverages you usually eat and drink at home or work during a typical day.		
Time	Foods & Beverages - please describe	Amount
Breakfast -		
Snack -		
Lunch -		
Snack -		
Supper -		
Snack -		

What part of meal planning do you find most difficult or unsatisfying? (Check all that apply)

Eating healthy foods   
  Eating out   
  Eating at regular times   
  Avoiding certain foods  
 Cooking/Preparing meals   
  Other: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ What weight are you most comfortable at? \_\_\_\_\_

Has your weight changed in the past 3 to 6 months?  No     Yes, describe \_\_\_\_\_