Student Health Services
The Ohio State University
1875 Millikin Road
Columbus, OH 43210

Last Name	First	MI
Inst ID		
(place patient label here)		

NUTRITION QUESTIONNAIRE

Patient Printed Name _____

Please answer the following questions and bring to your first appointment with the dietitian.

GENERAL INFORMATION

☐Undergraduate ☐Graduate What are you studying? _____

Family History: ☐Diabetes ☐High Cholesterol ☐PCOS ☐Thyroid Issues
☐Gluten Intolerance ☐Other_____

Have you ever seen a dietitian before? ☐Yes ☐No If yes, when? _____

What questions do you have for the dietitian? _____

Do you currently take any vitamins or supplements? ☐Yes ☐No
If yes, please list: _____

Where do you live? ☐Residence halls ☐Off campus - alone ☐Off campus – with roommates
☐Off campus – with family/spouse

Are you on a plan with dining services? ☐Yes ☐No
If yes, at what location(s) do you frequently dine?_____

PHYSICAL ACTIVITY

Do you currently exercise? ☐Yes ☐No

What do you do for aerobic activity (e.g., walking, running, biking, exercise class)? _____

How frequently do you exercise aerobically? _____ days/week for _____ minutes/day

How frequently do you strength train (e.g., weight lifting, machines, yoga)? _____ days/week
for _____ minutes/day

What do you do for leisure activities? _____

Do you have any exercise limitations? ☐Yes ☐No
If yes, please describe: _____

DIETARY HABITS

How would you rate your diet? ☐Excellent ☐Good ☐Fair ☐Poor

(Continue on next page)

DIETARY HABITS, continued

Has your appetite changed within the past month? ☐Yes ☐No
If yes, please explain:_____

Do you have any food allergies or food intolerances? ☐Yes ☐No If yes, please list: _____

Have you ever been on a diet? ☐Yes ☐No
If yes, what diets have you tried? _____

Are you currently following a special diet (e.g., low fat, low salt)? ☐Yes ☐No
If yes, what diet are you on? _____

Have you ever purposefully restricted food intake and attained what you or others felt was an extremely low or unhealthy weight? ☐Yes ☐No
If yes, please explain: _____

Have you ever vomited, used laxatives, fasted or exercised for long periods of time to lose weight?
☐Yes ☐No If yes, please explain: _____

Do you consume an excessive amount of calories in a 2 hour period, to the point of being painfully full and have negative emotions about it? ☐Yes ☐No
If yes, please explain:_____

Who prepares your meals? _____

Where do you eat your meals? _____

With whom do you eat your meals? _____

Out of 7 days in a week, how many days do you skip breakfast? _____

How often do you drink soda? ☐1 or less/week ☐2-4/week ☐5-10/week ☐11+/week

How often do you drink other sweetened beverages (e.g., sweet tea, sugary coffee drinks)?
☐1 or less/week ☐2-4/week ☐5-10/week ☐11+/week

What is your daily water intake (cups)? ☐1 or less/day ☐2-4/day ☐5-8/day ☐9+/day

How often do you eat fast food or go to a restaurant?
☐0-1/month ☐2-3/month ☐1-2/week ☐3-4/week ☐5+/week

How often do you drink alcohol? ☐0-1/month ☐2-3/month ☐1-2/week ☐3-4/week ☐ 5+/week

When you drink, on average, how many servings of alcohol do you drink in one sitting (1 serving = 12 oz beer, 5 oz wine, 1 oz liquor)? _____ serving(s)

Thank you for completing this questionnaire.

Dietitian Comments _____

Dietitian Signature _____ Date_____