MARIANNE ROMANO, M.P.A., R.D., C.D.N.
Certified Nutritionist, Registered Dietitian

Name______________________________________Sex: M F Age______Birthdate___________
Address______________________________ Home telephone__________ Office Tele.__________
_____________________________________Occupation_____________ Office email __________
Physician Name_____________________________ Other email___________________________
Why do you want a consultation with the nutritionist? _____________________________________
What is best way to contact you to arrange an appt.? ______________________________________
(All information provided is strictly confidential. At no time will any information be disclosed without signed permission.)

APPETITE

How would you describe your appetite? ( ) Hearty ( ) Moderate ( ) Poor

Do you have difficulty chewing, swallowing or digesting food? ( ) Yes ( ) No
Please explain____

EATING PATTERN AND ATTITUDES ABOUT FOOD

Do you eat at approximately the same time every day? ( ) Yes ( ) No ( ) Sometimes
If yes or sometimes, which meals and how frequently?__________________________________

Do you skip meals? ( ) Yes ( ) No
If yes, at what times? ____

Do you usually eat anything between meals? ( ) Yes ( ) No
If yes, name the 2 or 3 snacks (including bedtime snacks) that you have most often.___________
____

During one week, where do you eat most of your food? Home____ School____
Work_____ Restaurant_____ Other_________________ (identify)

Are there any foods or drinks that you regularly eat or drink because they're good for you?
( ) Yes ( ) No If yes, what? ____

FOOD CHOICES

Is there any food you can't eat or drink? ( ) Yes ( ) No If yes, what food(s)? ______________
What happens when you eat this food?
____

Are you allergic to any foods? ( ) Yes ( ) No If yes, what foods? _______________
What happens when you eat this food? ____

Are you on a special diet? (Example - diabetic, low fat, low salt) ( ) Yes ( ) No
Specify type of diet_______________________________Who recommended it? _____________

Have you been on special diets in the past? _____________What kind? ______________________

How many of the following beverages do you drink each day? Milk____ What kind? ____
Juice____ Soda____ Sport drinks____ Tea____ Coffee ____ what kind? ____ Other____

(over)

Please describe what you **usually** eat for breakfast, lunch, dinner and snacks.

Time	Meal	Food/Method of Preparation	Amount Eaten
______	Breakfast	________________________________	_______________
______	Snack	________________________________	_______________
______	Lunch	________________________________	_______________
		________________________________	_______________
______	Snack	________________________________	_______________
______	Dinner	________________________________	_______________
		________________________________	_______________
______	Snack	________________________________	_______________

Do you drink any alcoholic beverages (e.g. liquor, wine, and beer)? ( ) Yes ( ) No
If yes, what do you drink and how often? ____

WEIGHT INFORMATION

What is your current weight? ____________ Height? ___________ How do you feel about your weight right now? ( ) Too heavy ( ) Too thin ( ) OK

Are you **now** on a diet to lose weight? ( ) Yes ( ) No
If yes, what kind? _____________________________Who recommended it? _________________

Have you used any weight loss programs in the past? ( ) Yes ( ) No
If yes, please describe (e.g. weight watchers, diet pills) ___________________________________

Do you vomit or have diarrhea to keep your weight down? ( ) Yes ( ) No
( ) Every day ( ) 3-4 times/week ( ) Never ( ) Sometimes

SUPPLEMENTS AND MEDICATIONS & HEALTH INFORMATION

Are you taking any vitamin, mineral or herbal supplements? ( ) Yes ( ) No
If yes, what and how often (please provide brand if you know)_______________________________
____

Do you regularly take any "over the counter" **medications or** those **prescribed** by your doctor?
( ) Yes ( ) No If yes, what kind? ____

Do you have any of the following? ( ) Heart Disease ( ) Diabetes ( ) High Blood Pressure
( ) Kidney Disease ( ) Problems with stomach or bowel ( ) Other medical problems_________
____

EXERCISE & OTHER INFORMATION

How often do you exercise? ( ) Every day ( ) 3-6 times/week ( ) Once/week ( ) Sometimes
List kinds of exercise you do most often____

Do you smoke cigarettes? ( ) Yes ( ) No If yes, how many per day? _______________

Indicate the person in your household who plans and prepares meals. ________________________

I hereby authorize Marianne Romano to release this patient's nutritional care record for the purpose of communicating nutritional care plans with other pertinent medical care providers if necessary.

____ _______________
Signature **Date**
Relationship to patient____________________________

(3/06A)