

**Diet & Health Questionnaire:**

Name: \_\_\_\_\_ age: \_\_\_\_\_ date: \_\_\_\_\_

my favorite foods are:

My least favorite foods are:

I have allergies to :

Do you feel hungry at mealtime, or when you eat?    yes, very \_\_\_\_\_    a little \_\_\_\_\_  
no \_\_\_\_\_    sometimes \_\_\_\_\_

Do you over or under eat?

Circle the following items which you regularly consume, how often?

white sugar \_\_\_\_\_ coffee or caffeinated beverages \_\_\_\_\_ smoking \_\_\_\_\_

alcohol \_\_\_\_\_ raw foods \_\_\_\_\_ vitamins \_\_\_\_\_

**Breakfast:**

usual time: \_\_\_\_\_

usually eat: \_\_\_\_\_

\_\_\_\_\_

beverage?: \_\_\_\_\_

snack?(example and time):

\_\_\_\_\_

**Lunch**

usual time: \_\_\_\_\_

usually eat: \_\_\_\_\_

\_\_\_\_\_

beverage?: \_\_\_\_\_

snack?:

\_\_\_\_\_

**Dinner**

usual time: \_\_\_\_\_

usually eat: \_\_\_\_\_

beverage?: \_\_\_\_\_

snacks/dessert (example and  
time): \_\_\_\_\_

**Daily Routine:**

**Current Medications/Supplements/herbs:**

**Family History (major Health conditions):**

**Siblings:**

**Mother:**

**Father:**

**Maternal Grandmother:**

**Maternal Grandfather:**

**Paternal Grandmother:**

**Paternal Grandfather:**