

# DIETARY DATA

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Who prepares a majority of your meals? \_\_\_\_\_

How many meals do you eat each day?    1    2    3    4    5    6    >6

**Please Describe:**

Your Average Breakfast: \_\_\_\_\_

Your Average Lunch: \_\_\_\_\_

Your Average Dinner: \_\_\_\_\_

Your Average Snack(s): \_\_\_\_\_

How many glasses of water do you drink daily?    1    2    3    4    5    6    7    8    9    10    >10

What is the source of your water?    tap    spring    distilled    reverse osmosis

**Circle how frequently you eat each of the following foods:**

**N** = Never      **R** = Rarely (1-2 times/month)      **O** = Occasionally (2-4 times/month)

**W** = Weekly (at least once/week)      **D** = Daily (at least once/day)\*

\*If Daily, circle the number that indicates how many times per day that item is consumed.

Whole Milk	N	R	O	W	D	1	2	3	4	5	6	>6
Low Fat/Skim Milk	N	R	O	W	D	1	2	3	4	5	6	>6
Cheese	N	R	O	W	D	1	2	3	4	5	6	>6
Ice Cream	N	R	O	W	D	1	2	3	4	5	6	>6
Yogurt/Sour Cream	N	R	O	W	D	1	2	3	4	5	6	>6
Butter/Margarine	N	R	O	W	D	1	2	3	4	5	6	>6
Eggs	N	R	O	W	D	1	2	3	4	5	6	>6
Red Meat (beef, veal, lamb)	N	R	O	W	D	1	2	3	4	5	6	>6
Coffee	N	R	O	W	D	1	2	3	4	5	6	>6
Tea (non-herbal)	N	R	O	W	D	1	2	3	4	5	6	>6
Soda	N	R	O	W	D	1	2	3	4	5	6	>6
Cookies/Pastries	N	R	O	W	D	1	2	3	4	5	6	>6
Desserts	N	R	O	W	D	1	2	3	4	5	6	>6
Salt	N	R	O	W	D	1	2	3	4	5	6	>6
Soy/Miso	N	R	O	W	D	1	2	3	4	5	6	>6
Canned Vegetables	N	R	O	W	D	1	2	3	4	5	6	>6
Frozen Vegetables	N	R	O	W	D	1	2	3	4	5	6	>6
Cold/Hot Cereal	N	R	O	W	D	1	2	3	4	5	6	>6
Herbal Tea	N	R	O	W	D	1	2	3	4	5	6	>6
Poultry (chicken, turkey)	N	R	O	W	D	1	2	3	4	5	6	>6
Fish/Seafood	N	R	O	W	D	1	2	3	4	5	6	>6
Beans/Legumes	N	R	O	W	D	1	2	3	4	5	6	>6

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Fresh Vegetables	N	R	O	W	D	1	2	3	4	5	6	>6
Whole Grains (millet, oats, brown rice, etc.)	N	R	O	W	D	1	2	3	4	5	6	>6
Vegetable Oil	N	R	O	W	D	1	2	3	4	5	6	>6
Oleo/Crisco Oil	N	R	O	W	D	1	2	3	4	5	6	>6
Juices	N	R	O	W	D	1	2	3	4	5	6	>6
Fresh Fruit	N	R	O	W	D	1	2	3	4	5	6	>6
Canned Fruit	N	R	O	W	D	1	2	3	4	5	6	>6
Alcohol	N	R	O	W	D	1	2	3	4	5	6	>6
Bread/Pasta/Pancakes	N	R	O	W	D	1	2	3	4	5	6	>6
Peanuts/Peanut Butter	N	R	O	W	D	1	2	3	4	5	6	>6
Other Nuts/Nut Butters	N	R	O	W	D	1	2	3	4	5	6	>6
Mushrooms	N	R	O	W	D	1	2	3	4	5	6	>6
Sugar/Honey/Syrup	N	R	O	W	D	1	2	3	4	5	6	>6

Other foods that you eat daily or weekly: \_\_\_\_\_

Type of Cookware Used:      stainless steel      aluminum      glass      enamel      iron      copper      non-stick

Are you willing to make dietary changes in order to accomplish your goals if necessary?    Yes    No

If there is anything else that you would like the doctor to know about your eating habits, please write it below.