Diabetes & Nutrition Teaching Center
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Patient Nutrition Self-Assessment

To be completed by patient _____ Date: _____
Signature
Doctor who referred you: _____

1. Demographics:

Name_____
Address _____
Phone _____ Work Phone _____

Sex:
___ male
___ female

Marital Status:
___ Single ___ Married
___ Divorced ___ Widow

Race:
___ Caucasian ___ African American
___ Hispanic ___ Asian
___ Other ___ American Indian/Eskimo

Age: _____ Birthdate: _____

What kind of work do you do: _____ Hours worked: _____ Shift worked: _____

Retired:
___ Yes
___ No

Religion:
___ Catholic ___ Protestant
___ Jewish ___ Other

Previous Diabetes Education:
___ Yes When: _____
___ No Where: _____

Do you live with anyone? ___ Yes ___ No If yes, who: _____

What grade of school did you complete? _____
Do you have enough money to buy your food? ___ Yes ___ No

2. Medical History

Do you have any barriers to learning/special education needs? ___ Yes ___ No
If yes: ___ Visual ___ Hearing ___Literacy ____ Other _____

Do you have:

___ Yes ___ No High Blood Pressure
___ Yes ___ No Heart Disease
___ Yes ___ No Kidney Disease
___ Yes ___ No Numbness, pain, burning
___ Yes ___ No Eye Problems
___ Yes ___ No Foot Problems
___ Yes ___ No Excess Weight
___ Yes ___ No Chronic Constipation
___ Yes ___ No Frequent Urination
___ Yes ___ No Get Infections Often
Other: (list) _____

Patient Nutrition Education Self-Assessment, con't

List any surgeries: _____

List all medications: _____
Do you take vitamin/mineral pills? ___ Yes ___ No If yes, list: _____

Do you have any allergies? ___ Yes ___ No If yes, list: _____

3. Activity

Exercise: ___ Never ___ 1-2 times/week ___ 3-4 times/week ___ 5-7 times/week
Time of day you exercise _____ How Long _____minutes
Type: ___Walk _____Swim _____Bike _____ Jog ___ Aerobics _____Other _____

4. Self Care

Last dilated eye exam (Dr. puts drops in your eyes)? _____

Smoke/chew ___Yes ___ No Alcohol ___ Yes ___ No ___ Quit
If yes, how much/types _____

Have you been in the hospital or Emergency Room in the past 12 months? ___ Yes ___ No
Reason(s): _____

On a scale of 1 to 10, how much stress do you have in your life? (1 = least & 10 = most) _____
Reason(s): _____

How would you rate your health? ____ Poor ____ Fair ____Good ____ Very Good

5. Nutrition

Height _____ Weight _____ What do you want to weigh? _____

Have you lost/gained in weight in the last 6 months? ___ Yes ___ No
How much have you lost? _____ (or) How much have you gained? _____

Have you ever been on a diet before? ___ Yes ___ No
If yes, calorie level _____

Did you follow it ___ Yes ___ No

Have you ever used exchange list? ___ Yes ___ No

Patient Nutrition Self-Assessment Cont'd

Do you change your diet for other reasons? ___ sugar ___ salt ___ fat ___ protein
If other, explain: _____

Do you have any food allergies or foods you avoid that don't agree with you _____
If yes, list the foods: _____

Do you skip meals? _____ If yes, which meals: _____

Do you eat meals/snacks at the same time every day? ___ Yes ___ No

Do you eat differently on the weekends? ___ Yes ___ No
If yes, explain: _____
Who shops for your food? _____

Do you drink milk? ___ Yes ___ No If yes, which meals? _____
What kind? ___ Skim ___1% ___2% ___ whole

How often do you eat out (meals per week): ___ 0-1 ___ 2-4 ___ 5-8 ___ more than 9
What type of places do you eat out? _____

Please list any foods you don't like: _____

Do you have any problems with:

___ Chewing ___ Swallowing ___ Heartburn/indigestion ___ Vomiting ___ Binge eating

___ Laxative abuse ___ Constipation ___ Diarrhea ___ often feels bloated after eating

___ Not eating enough

Do you salt your food? ___ Yes ___ No

Patient Nutrition Self-Assessment cont'd

What type of fat do you use when you cook? ___ Oil, type _____ ___ Butter
___ Margarine ___ Shortening
___ Stick ___ Fatback
___ Tub ___ Bacon
___ Squeeze

How often do you eat or drink these foods:

	Daily	>1 per week	Seldom	Never
Eggs				
Beef/Pork				
Poultry				
Fish				
Fried Foods				
Diet Sodas/Beverages				
Milk				

	Daily	>1 per week	Seldom	Never
Fruit Juice				
Vegetables				
Sweets/Desserts				
"Dietetic Foods"				
Reg. Sodas/Beverages				
Coffee/Tea				

Please list the foods and beverages you usually eat and drink at home or at work during a typical day:

Time	Morning Food	Amount	Time	Afternoon Food	Amount	Time	Evening Food	Amount
	Breakfast:			Lunch:			Dinner:	
	Snack:			Snack:			Snack:	

What is the hardest part of following your diet? _____
What do you wish to learn about eating for diabetes?_____

 Signature, Title:_____Date: _____