WARREN COUNTY COMBINED HEALTH DISTRICT
Dietary History

Name__________________________________ Date_____________

Birth Date________________

What you eat is important to your health. Please answer the following questions so we can help you meet your nutritional needs.

1. What kind of beverages do you drink daily?____
   ____________________________________How much?____________________________
2. How often do you add salt to foods?__________________
3. What kind of snacks do you eat?____
   _________________________How often?_________________________
4. Do you take vitamins or other supplements?______What kind?______________________
5. Who prepares your meals?______________________________________
6. How often do you eat out at restaurants?____________________________
7. How would you describe your appetite? Good___ Fair___ Poor___
8. Are you on a diet plan to lose weight?____ Gain weight?____
9. Are you on a special diet?___What type?____________________________
10. Do you have any food allergies?___What food(s)?__________________________________
11. Do you have any health problems?_________________________________
12. Are you taking any medications?______What kind?_________________________________
13. Do you have any questions for the nutritionist?________
14. Are you planning a pregnancy in the next year?________

What and how much (proportions) did you eat yesterday?

Breakfast:
____
____

Snack:
____

Lunch:
____
____

Snack:
____

Dinner:
____
____

Snack:
____