Hartford HealthCare
The Hospital of Central Connecticut

Patient Name: _____

Date of Birth: _____

**HOCC Outpatient Nutrition Center**
**PRE-EVALUATION**

Date: _____

Please check any medical history: ☐ Diabetes ☐ Prediabetes ☐ High Cholesterol ☐ High Blood Pressure ☐ GERD ☐ Thyroid Disorder ☐ Overweight ☐ Stroke ☐ Cancer ☐ Depression ☐ Anxiety ☐ Heart Disease ☐ Sleep Apnea ☐ Weight Loss Surgery ☐ Lung Disease ☐ Kidney Disease ☐ Other (please list): _____

Height: _____ Weight: _____ Any recent changes to weight? ☐ Yes ☐ No

Comment: _____

What would you consider to be a healthy weight/goal weight for you? _____

Do you take vitamins, minerals, herbs, or any other food or nutritional supplements?
☐ Yes ☐ No Please list: _____

Please list if you have any food allergies or intolerances: _____

Do you exclude certain foods due to vegetarianism or religious restrictions? ☐Yes ☐No
If yes, please explain: _____

Do you smoke tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No How often? _____ How much? _____

How many people live in your household? _____ Ages: _____

Who usually does the cooking? _____ Shopping? _____

How often each week do you eat in restaurants, cafeterias, away from home, or get take out?

Breakfast _____ x/week Lunch _____ x/week Dinner _____ x/week

Over the past month I exercised an average of _____ times per week.

Type of exercise: _____ Number of minutes per session: _____

Do you have any physical problems that limit your activity? ☐ Yes ☐ No

If yes, please describe: _____

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Please write down a TYPICAL day of eating.

| Meal or Snack | Time | What did you eat, and how much? |
|---|---|---|
| Breakfast/1st Meal | | |
| Midmorning Snack | | |
| Lunch/2nd Meal | | |
| Afternoon Snack | | |
| Dinner/3rd Meal | | |
| Nighttime Snack | | |

**Nutrition History**

Rate your appetite: ☐ Good ☐ Fair ☐ Poor

Do you have any eating or digestion problems?
☐ Chewing ☐ Swallowing ☐ Stomachache ☐ Diarrhea ☐ Constipation
☐ OTHER:

1. Please describe any meal plans, diets, or weight loss attempts you've tried in the past: _____

_____

_____

2. Do you currently follow any type of meal plan, such as Weight Watchers, low cholesterol, or low sodium? ☐ Yes ☐ No

If yes, please describe_____

3. Do you regularly skip meals? ☐ Yes ☐ No

If yes, which meals do you skip most often? _____

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4. Where do you do most of your eating?

☐ Table ☐ In front of the T.V. ☐ In the car ☐ Other: _____

5. Which sources of protein do you eat? (please check all that apply)

☐ Chicken ☐ Beef ☐ Pork ☐ Turkey ☐ Fish/Shellfish ☐ Eggs

☐ Tofu ☐ Cheese ☐ Soybeans ☐ Beans (kidney, black, chickpeas)

☐ Egg whites/substitutes ☐ Greek/protein yogurt ☐ Cottage cheese

☐ Nuts ☐ Peanut butter ☐ Cow's milk/Lactaid ☐ Protein drinks/powders

6. What kinds of vegetables do you eat (if any)? _____

_____

7. What kinds of fruits do you eat (if any)? _____

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8. What types of foods or drinks do you usually snack on (examples: fruit, Potato chips, candy, cookies, crackers, pretzels, soda, sandwiches, etc.)

_____

_____

9. What types of beverages do you drink throughout the day?

_____

_____

## Food Assessment

10. Within the past 12 months, I worried whether my food would run out before I/we had money to buy more: ☐ Yes ☐ No

11. Within the past 12 months, the food purchased did not last and I/we did not have money to buy more: ☐ Yes ☐ No

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## Lifestyle

12. What are your usual work hours?

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13. Do you feel that you have an excessive amount of stress in your life?
☐ Yes ☐ No

If yes, how do you manage your stress? _____

14. Is there anything that you would like the dietitian to discuss with you at today's visit, or any concerns you would like us to know about?

_____

_____

_____

_____

## Medications

Please list ALL your current PRESCRIBED MEDICATIONS, **or we can copy your list of medications if you have it with you.**

| Name of Medication | Dosage | Times per day | Reason for medication | Any side Effects? |
|---|---|---|---|---|
| | | | | |
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