Baptist Health Lexington
Outpatient Nutrition Services
Nutrition Assessment Form

Please answer as many questions as you can. Someone can help you fill this out if needed.

General Information

1. Name: (Mr /Ms/ Mrs) _____
2. Birthdate: _____
3. Where do you work? _____
4. What do you do? _____
5. Last grade of school completed: _____

Medical Information

1. What medical problems are you being treated for? (*please list)*

2. List any medications and vitamin/mineral/herbal supplements you are currently taking:

Nutritional Information

1. Height _____ Weight _____ Have you had weight changes recently? Yes or No
   If yes, please describe: _____
   What is your desirable body weight? _____
   Have you tried to lose weight before? Yes or No
   If Yes, please list plans/programs tried, when you tried it, and your success with each:
   _____
   _____
   _____
   _____
   What is your motivation to lose weight? _____

2. Have you in the past or do you currently use tobacco products? Currently In past Never
   If yes, what and how much each day?_____ For how long? _____years
   Have you been advised to quit? _____ By Whom? _____When?_____

3. Do you use alcohol? Yes or No
   If yes, what and how much and how often? _____

4. Do you have any food allergies/intolerances? Yes or No
If yes, please describe: _____

5. Do you have any history of eating disorders? Yes or No
If yes, please describe: _____

6. List any cultural diet influences that are important for you to follow
(ex: religious food restrictions): _____

7. Do you have any problems chewing food? Yes or No

8. Who prepares meals each day? _____

9. List any food cravings/trigger foods you have:

10. Would you call your self a "stress eater"? Yes or No

11. Would you call yourself a "boredom eater"? Yes or No

12. How often do you eat out and where?

Type of Restaurant	How Often	Usual Food Choice

13. Do you use Food Assistance programs (WIC, food stamps, food bank) Yes or No
14. Do you need information about Food Assistance programs? Yes or No

15. How often do you eat the following foods:

Milk	_____ times each day	Ice Cream	_____times each day
Fruit	_____ times each day	Snack Foods	_____ times each day
Vegetables	_____ times each day	Pop	_____ # day (diet or regular?)
Juice	_____ times each day	Ethnic foods	_____ times each day
Candy/Chocolate	_____ times each day	Alcohol	_____ times each day
Baked goods	_____ times each day	Caffeine	_____ times each day
Desserts	_____ times each day	Artificial Sweeteners:	_____ servings/day

16. How many meals do you eat a day? _____ How many snacks? _____
Do you skip any meals? If so, which meals? _____

17. What is the biggest challenge you have with your diet? (*please describe)*

18. Support Plan: What type of support do you currently use to help you with your health issues? (*Example: gym membership, Weight Watchers classes, Friend who walks with you, Books)*

19. Please write down everything you can remember you ate in the last 24 hours (1 day). **Write down when, what, and how much you ate in the space below. Don't forget drinks.**

What Time	**What You Ate**	**How Much**
Breakfast	*Example: Cheerio, skim milk*	*Example: 1 cup cereal, 1/2 cup milk*
Snack		
Lunch		
Snack		
Dinner		
Snack		

Physical Activity

1. Are you currently involved in an activity/exercise program? Yes or No
   If **Yes**, please describe what activity/how frequent you engage in it:
   Activity _____ Frequency (ex: daily, once a week, etc.)

2. How many minutes do you spend on exercise each day? _____ minutes
3. How would you rank exercise as an important healthy lifestyle practice (circle one)?

1 2 3 4 5 6 7 8 9 10

(not important --------very important)

Communication

1. To help the teacher provide a good experience for you, please share any of the information about yourself so we can support your needs in class: *(circle all that apply)*

Hearing loss	Vision loss (cannot read newspaper)
Reading problems	Manual dexterity problems
Changes in sensation	Financial stress/problems
Religious influences about health	Other: _____

2. How do you learn information best? *(circle one)*
   Discussion Listening Reading Watching (visual) Doing
3. Do you use computers to email? Yes or No
   Do you use computers or phone app's for health information/records? Yes or No

Please write any other information you would like to share:

For PREGNANT patients ONLY, please answer the following:

- When is your due date _____
- What was your usual pre-pregnancy weight? _____
- Do you plan to breast feed or bottle feed? _____
- How much weight have you gained in the last month? _____
- Are you taking prenatal vitamins? _____
- Do you have indigestion or other food related problem? **Yes or No**
  If yes, please describe: _____

Please sign your name and write today's date:

Signature: _____ ***Date:*** _____

Reviewed by : _____ Date: _____

Registered Dietitian

Revised 4/16, 4/17

BAPTIST HEALTH
LEXINGTON

Dear Participant,

We are asking our patients to help us learn how well patients can understand the medical information that the nurses and dietitians give them. Your answers will help us learn how to provide medical information in ways that patients will understand. This questionnaire has 6 questions and it will only take about 3 minutes to complete. Answer the questions as best as you can. It is okay to leave an answer blank. After completion, please bring the answer sheet along with your completed assessment form to your appointment. Thank you for your time.

Baptist Health Lexington
Outpatient Diabetes and Nutrition Services
(859) 260-5122

Diabetes Education
&
Nutrition Education

This information is on the back of a container of a pint of ice cream (see below for label).

1. If you eat the entire container, how many calories will you eat?
   Answer: _____

2. If you are allowed to eat 60 grams of carbohydrates as a snack, how much ice cream could you have?
   Answer: _____

3. Your doctor advices you to reduce the amount of saturated fat in your diet. You usually have 42g of saturated fat each day, which includes one serving of ice cream. If you stop eating ice cream, how many grams of saturated fat would you be consuming each day?
   Answer: _____

4. If you usually eat 2,500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving?
   Answer:_____

5. Pretend that you are allergic to the following substances: penicillin, peanuts, latex gloves, and bee stings.
   Is it safe for you to eat this ice cream? Yes or No (please circle the correct answer)
   If no, why not? Answer:_____

Ice Cream Label

Nutrition Facts

Serving Size	½ cup
Servings per container	4
Amount per serving	
Calories 250	Fat Cal 120
	%DV
Total Fat 13g	20%
Sat Fat 9g	40%
Cholesterol 28mg	12%
Sodium 55mg	2%
Total Carbohydrate 30g	12%
Dietary Fiber 2g	
Sugars 23g	
Protein 4g	8%

*Percentage Daily Values (DV) are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

Ingredients: Cream, Skim Milk, Liquid Sugar, Water, Egg Yolks, Brown Sugar, Milkfat, Peanut Oil, Sugar, Butter, Salt, Carrageenan, Vanilla Extract.

Please check one:

- □ I completed the questionnaire on my own
- □ I had help answering these questions
- □ I do not wish to fill this out

Thank you for your participation.

Place patient sticker here
(for office use only)