Mercy

Mercy Hospital St. Louis
Nutrition Services

Mercy Dietitian Services
General Background Questionnaire

Date: _____ Name: _____ Spouse's name: _____

Phone Number(s): Home: _____ Alternate: _____ work/cell

Physician(s): _____

1. Age: _____ Date of Birth: _____/_____/_____ Ht: _____' _____" Wt: _____
2. Marital Status: (Circle One) Married / Single / Divorced / Widowed / Domestic Partnership
3. Occupation: _____ Work Hours: _____
4. Personal and Family Medical History:
   Please place a (X) in column A if you currently have or have had any of the following health problems.
   Please place a (X) in column B if any members of your immediate family (ie: parents, siblings, grandparents) have had any of the following conditions:

	A. Yourself	B. Family
1. Overweight		
2. Diabetes		
3. Hypoglycemia (Low Blood Sugar)		
4. High Blood Pressure		
5. High Cholesterol		
6. Heart Attack		
7. Stroke		
8. Bypass Surgery		
9. Angina		
10. Cancer		
11. HIV		
12. Kidney Disease		
13. Psychiatric History		
14. Orthopedic Problems (Knees & Joints)		
15. Other (Please Specify):		

5. Living Situation: *(Please circle all that apply)*
   Live Alone / Live with: Spouse / Roommate / Children (# of children _____)

6. Who does the cooking in your household? _____ The grocery shopping? _____

7. How is the food typically prepared? *(Please circle all that apply)*
   Baked / Fried / Microwaved / Grilled / Other(s): _____

8. How often, and at which meals, do you eat out during the week?
   Breakfast _____ / Lunch _____ / Dinner _____ / Others _____

9. What types of restaurants do you usually frequent? *(Please circle all that apply)*
   Fast Food / Salad Bar-Buffets / Ethnic Foods / Others _____

10. Do you smoke? Yes _____ No _____ (Quit? _____ months _____ years)
11. Do you drink alcohol? Yes _____ No _____ What type? _____ How often? _____
12. Do you do any regular physical exercise? Yes _____ No _____ If yes, what type? _____

    How often? _____
13. Have you had any previous nutritional counseling? Yes _____ No _____
14. Have you been on any weight loss program? Yes _____ No _____

    Please specify: _____
15. Do you have difficulty chewing or swallowing food? Yes _____ No _____
16. Are there any foods you avoid for religious, health, or philosophical reasons? Yes _____ No _____

    If yes, explain: _____
17. Do you have any food allergies or intolerances? Yes _____ No _____

    If yes, explain: _____
18. How is your appetite? Good / Fair / Poor
19. Have you made any significant changes in your eating recently? Yes _____ No _____

    If yes, explain: _____
20. Do you take vitamins, minerals, herbal, or nutritional supplements? Yes _____ No _____

    If yes, please list: _____
21. Are you currently taking prescription medication? Yes _____ No _____

    If yes, please list: _____
22. Do you experience difficulty reading? Yes _____ No _____ If yes, explain: _____

    _____
23. Are you experiencing any difficulty with balance or walking today? Yes _____ No _____

    If yes, explain: _____

    Do you use assistive walking devices? _____
24. Do you feel unsafe at home? Yes _____ No _____ If yes, explain: _____

Weight History

25. Highest weight as an adult (18 years old and above): _____ When? _____

    Lowest weight as an adult (18 years old and above): _____ When? _____
26. Has your weight changed over the past year? Yes _____ No _____

    If yes, how many pounds have you gained? _____ Lost? _____

    Describe any significant events in your life which influenced this: _____

    _____
27. At what weight have you felt your best, or think you would feel your best? _____
28. What significant problems, if any, have you encountered with previous weight loss efforts?

    _____

INDICATE BELOW WHAT YOU EAT IN A TYPICAL DAY AND WHEN. ***(Include Meals, Snacks, Beverages, Etc.)***	
BREAKFAST	
TIME:	
SNACK	
TIME:	
LUNCH	
TIME:	
SNACK	
TIME:	
DINNER	
TIME:	
SNACK	
TIME:	