In order to assure the nutritional needs of each Resident, it is helpful to have a diet history. Please answer the following questions to the best of your ability.

Resident Name:_____ **Date:** _____ **Adm. #:** _____

Person supplying information other than Resident: _____

1. Have you ever been on a special diet? Yes:____ No: ☐
   If YES, what do you know about the diet? _____

2. What was your usual weight range for the past three years? _____ pounds.
   Have you lost weight in the last 30 days? Yes____ No ☐
   If YES, how many pounds? _____ Reason for loss: _____
   Have you lost weight in the last 60 days? Yes____ No ☐
   If YES, how many pounds? _____ Reason for loss: _____

3. Do you eat between meals on most days? Yes____ No ☐
   Do you like an evening snack? Yes____ No ☐
   If YES, what foods do you like? _____

4. Do you drink alcohol – at least once a week? Yes____ No ☐
   Please state item (beer, wine, etc.) and how often? _____

5. Do you have any difficulty chewing? Yes____ No ☐
   Do you have any difficulty swallowing? Yes____ No ☐
   Are you having any pain or discomfort in your mouth Yes____ No ☐
   If YES to any of the above, please describe _____

6. Do you eat from any of the following food groups?
   Milk – 2 or more glasses a day? Yes____ No ☐
   Meat, Fish, Poultry, Cheese, Eggs (6 oz or more a day) Yes____ No ☐
   Do you eat a citrus fruit or tomato every day? Yes____ No ☐
   Do you eat dark green and yellow vegetables? Yes____ No ☐
   Do you eat bread and cereals – 4 or more a day? Yes____ No ☐

7. Do you eat salads (lettuce, tomato, cucumbers, etc.) Yes____ No ☐

8. Have you taken vitamins or minerals Yes____ No ☐ Specify: _____
   Mineral oil? Yes____ No ☐ Specify: _____
   Antacids such as Mylanta Yes____ No ☐ Specify: _____

9. Are you bothered with constipation? Yes____ No ☐
   If YES, what foods have helped? _____

10. Are you allergic to any foods? _____
    If YES, please explain what happens if you eat this food: _____

11. Do you need any assistance in feeding? Yes____ No ☐
    Describe what is helpful? _____
    Do you use any special feeding utensils? _____
    If YES, please explain _____

12. Do you have any religious food preferences? Yes____ No ☐
    If YES, specify: _____

13. What beverages are taken with meals? _____

14. What are your favorite foods? _____

15. What foods are particularly disliked? _____

16. Describe any unusual food habits or special needs. _____

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE ASK TO SEE THE DIETICIAN. OUR PRIMARY GOAL IS TO SATISFY THE NUTRITIONAL NEEDS OF EACH RESIDENT.

Submit: