The Association of Minimally Invasive Gynecologic Surgeons
…dedicated to safe, state-of-the-art surgery and health life-styles for women of all ages

Nutrition Counseling Questionnaire

Date: ____________

Name: ________________________ **Phone Number:** _________________

Email: __________________ **Address:** _____________________________

Age: ____ Birthdate : _____________ **Ht:** _______ **Wt:** ________

Referred By: ______________________________________

Medication : ______________________________________

I. Diet History

Indicate below what you typically eat for Breakfast, Lunch, Dinner and any snacks. Also indicate serving size, i.e. ½ cup=half a baseball,1 cup = 1 baseball, 3 oz = a deck of cards.

Meal	Food	Serving Size
Breakfast	_________________________	___________
	_________________________	___________
	_________________________	___________
	_________________________	___________
Lunch	_________________________	___________
	_________________________	___________
	_________________________	___________
	_________________________	___________

Dinner ____________________________ ____________

Dinner cont. ____________________________ ____________

____________________________ ____________

____________________________ ____________

Snacks ____________________________ ____________

Food Likes: ____

Food Dislikes: ____ _

I .Goals

Please indicate below your eating pattern, physical activity
and body weight goals

Eating Pattern Goal: Like, “eat four servings of vegetables a day”

____

____

Physical Activity Goal: Like, “walk 30 minutes a day”

____

____

Body Weight Goal (short term: 3 months): ______________________

II. Exercise

Please indicate below:

_______ I exercise at least 3 days a week for 30 minutes
(brisk walking, aerobics, swimming, bicycling, etc.)

_______ I exercise at least 3-5 days a week for 60 minutes

______ I exercise less than 3 days a week for 30 minutes

______ Other: Explain: ______

______ I do not exercise at all.

Preferred method of exercise:

_____ Walking _____ Aerobics _____ Swimming _____ Bicycling

_____ Yoga _______________________________________ Other

IV .Weight Loss History

Diets tried in the past: _________________________________

____

Weight Lost : ____

Weight Re-gained : ___________________________________

Time Frame : ____

Successes: ____

What prevented you from keeping the weight off ?

____

V. Nutrition Counseling

I would like nutrition counseling on:

_____ Weight Loss   _____ Heart Healthy (Low fat)

____________________________________Other