Nutrition Health Profile

ANCHORAGE RADIATION ONCOLOGY CENTER

Date:_____ Patient Name:_____

Patient DOB: _____

Nutrition counseling is made possible with a thorough understanding of the patient physically, mentally, and emotionally. PLEASE complete all information and questions.

The nutritionist will address your total health picture. We would like to know your top 2 health concerns, symptoms and/or goals:

1. _____
2. _____

Foods and Dietary

Have you experienced any weight changes in the last 6 months?	☐ YES ☐ NO	☐ Gain_____lbs. ☐ Loss_____lbs.
Are you currently on a diet?	☐ YES ☐ NO	Does your Diet have a name?_____
Do you diet frequently?	☐ YES ☐ NO	Was your diet recommended by someone?_____
Do you eat processed /refined foods? (Pasta, white bread, Potatoes, snacks, desserts, sugar, candy, artificial sweeteners, MSG, etc.)		☐ YES ☐ NO
Do you have a problem with gas, belching, pain, or cramps?	☐ YES ☐ NO	Please explain:_____
Do/Does any food(s) cause you discomfort?	☐ YES ☐ NO	Please explain:_____
How is your appetite?	_____	

Please give an example of your typical breakfast, lunch, dinner, & snacks.

	Breakfast	Lunch	Dinner	Snacks
Normal Time:				
Description:				

Details:_____

What is your daily water intake?				
☐ 2 glasses (16 oz)	☐ 4 glasses (32 oz)	☐ 8 glasses (64 oz)	☐ 10 glasses (80 oz)	☐ Other:_____

Other Beverages (Check all that apply)

Beverage	Quantity/Frequency	Beverage	Quantity/Frequency
☐ Soda/Pop	_____Cans ☐ Daily ☐ Weekly	☐ Coffee ☐ Regular ☐ Decaf	_____Cups ☐ Daily ☐ Weekly
☐ Juice	____Glasses ☐ Daily ☐ Weekly	☐ Wine	____Glasses ☐ Daily ☐ Weekly
☐ Milk ☐ Cow ☐ Other:_____	____Glasses ☐ Daily ☐ Weekly	☐ Beer	____Glasses ☐ Daily ☐ Weekly
☐ Tea ☐ Black ☐ Herbal	____Glasses ☐ Daily ☐ Weekly	☐ Hard Liquor	____Glasses ☐ Daily ☐ Weekly

Vitamins/Supplements ☐ *None*

Vitamin/Supplement	Dose (per use)	Total dose (per day)	Brand Name	Reason

Habits/Environment

Please rate the following on a scale of 1-5 with 1 being low and 5 being high.

Please rate your regular daily energy level.	☐1 ☐2 ☐3 ☐4 ☐5	
Please rate your stress levels.	☐1 ☐2 ☐3 ☐4 ☐5	
Do you work in a healthy environment?	☐ YES ☐NO	
Do you have a supportive relationship?	☐ YES ☐NO	
Do you fall asleep easily and sleep soundly?	☐ YES ☐NO	Please explain_____
Do you take anything to help you sleep?	☐ YES ☐NO	Please explain_____

How many times do you urinate each day?	☐1 ☐2 ☐3 ☐4 ☐5
Do you get up at night to urinate?	☐ YES ☐NO
Do you have urinary tract infections often?	☐ YES ☐NO
How many bowel movements do you have per day?	☐1 ☐2 ☐3
Do you have or have you ever had blood in your stool?	☐ YES ☐NO

Bowel Color and consistency, Check all that apply.	
☐ Brown/Tan ☐ Green or Black ☐ Yellow or Red	☐ Soft ☐ Medium ☐ Hard

Exercise

Do you engage in exercise or regular physical activity?	☐ YES ☐NO

Type	Duration/Workout	Times/Week
Walking		
Running		
Hiking		
Bicycle		
Rowing		
Strength Training		
Pilates/Yoga		
Other:_____		

Thank you for completing the health profile questionnaire. We look forward to meeting you.