

PCOS Nutrition Questionnaire

Name: _____ Age: _____ Date of Birth: _____

Medical History

Please check if you or a family member has a history of any of the following conditions:

Condition	Family	Self	Condition	Family	Self
Anemia			Kidney Disease		
Blood Clots/Clotting Difficulty			Obesity		
Cancer			Osteoporosis		
Diabetes			Ulcer Disease		
Eating Disorder			Urinary Tract Infections		
High Blood Pressure			Hyperparathyroidism		
High Cholesterol			Other:		

Please indicate by check mark if you have any of the following problems/concerns:

Constipation Diarrhea Heartburn Nausea
 Vomiting Weight loss other (please list): _____

What is your current weight? _____ pounds
 What would you consider to be your "normal" weight? _____ pounds
 What is the weight you would like to be? _____ pounds
 Height: _____ feet/inches

Please identify any health conditions you have:

Have you ever had your Body Fat % tested before? _____ YES _____ NO
 If yes, when was it tested and what were the results? _____

Have you ever had your thyroid checked before? _____ YES _____ NO
 If yes, when was it tested and what were the results? _____

Please list all medications/vitamins/minerals/supplements you are currently taking:

Name	Dosage	Frequency	Prescribed by (as appropriate):

Nutrition History

I eat ___ meals per day: 1 2 3 4 5 6 +6

Please indicate by check mark if you follow any special diet:

___ Carbohydrate restricted ___ Fat restricted ___ Vegan ___ Vegetarian
___ Weight loss ___ Sodium restricted ___ Macrobiotic ___ Other: _____

If you follow a special diet, whom recommended it and why? _____

Please list any known food allergies:

Please list any cravings you are currently experiencing:

Which of the following best describes your alcohol usage:

- ___ I never drink alcohol.
___ I currently drink occasionally (≤ 1 time a week).
___ I drink 2 to 3 days of the week.
___ I drink 4 to 5 days of the week.
___ I drink +5 days of the week.

If you drink currently, how many drinks on average do you have at one time? _____

Please list the times of day and the foods you typically eat at each meal:

	Time of Day	Foods Typically Eaten
Breakfast:		
Lunch:		
Dinner:		
Snacks:		

How many times per week do you eat at a restaurant (including fast food)? _____ times per week

Please, list any specific questions or concerns you may have regarding nutrition:

Exercise History

How often do you engage in physical activity?

Type of Activity:	Total Minutes in One Session:	Times per Week:

If you currently exercise, for how long have you been exercising regularly (≥ 2 times a week)? _____

If you are not currently on an exercise regiment, are you interested in starting one? _____ YES _____ NO

PCOS History

Have you had a physician give you a medical diagnosis of Polycystic Ovarian Syndrome (PCOS)? _____ YES _____ NO

If yes, how was the diagnosis made?

Do you have a history of any of the following (check all that apply)?

- | | |
|--|---|
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Uterine fibroids |
| <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Breast lumps or fibrocystic breast disease |

Do you have a family history of any of the following (check all that apply)?

- | | |
|---|--|
| <input type="checkbox"/> PCOS | <input type="checkbox"/> Excessive hair growth |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Thyroid abnormalities |
| <input type="checkbox"/> Hormonal problems | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Diabetes | |

Which symptoms are your currently experiencing as a result of your PCOS?

- | | |
|--|---|
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Insulin resistance |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Facial hair |
| <input type="checkbox"/> Specifically: _____ | <input type="checkbox"/> Losing hair |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hot flushes |

Which of the following treatments for PCOS have you attempted?

- | | |
|--|--|
| <input type="checkbox"/> Low carbohydrate diet | <input type="checkbox"/> Acne medication |
| <input type="checkbox"/> General healthy eating | <input type="checkbox"/> Psychological counseling |
| <input type="checkbox"/> Insulin sensitizing medications | <input type="checkbox"/> Nutritional counseling |
| <input type="checkbox"/> Oral Contraceptive | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Exercise/Personal Trainer |
| <input type="checkbox"/> Mood stabilizing medication | <input type="checkbox"/> Other |
| <input type="checkbox"/> Medications to regulate period | <input type="checkbox"/> Please describe: _____ |
| <input type="checkbox"/> Specifically: _____ | _____ |

Who recommended these treatments?

What were the results of the treatments you have attempted?

Please list any pertinent lab results:

What are your main goals you are seeking to accomplish through nutritional counseling?

What specific components of nutritional counseling are you looking for and that you feel would be most helpful to you?

What other information do you think I would find helpful that is particularly relevant to you?

Is there any other additional information that you believe is important for us to know?

I certify that all the information I have provided above is accurate and complete to the best of my knowledge as of the date of my signature below. I agree to accept responsibility for omissions regarding my failure to disclose any past or currently existing health/medical conditions. In addition, I acknowledge receiving Nutrition Specialists, LLC and Budding Baby's HIPPA Privacy Notice.

Signature: _____

Date: _____

Print Name: _____

Please complete this 3-day food diary depicting all food and beverage intake, providing as much detail as possible.

Food Diary Day 1

Time of Day	Meal Eaten	Food Eaten (please be specific including amounts, types of food, etc.)
Sample Record		
8:30 am	Breakfast	1 ½ cup Chocolate Chex with ½ cup 2% milk
		1 cup regular coffee with 2 Tbsp half and half and 1 Tbsp sugar
		1 homemade cinnamon bun (about size of my fist)
		2 slices bacon
	Breakfast	
	Lunch	
	Dinner	
	Snack	
	Snack	
	Snack	
	Other	

Food Diary Day 2

Time of Day	Meal Eaten	Food Eaten (please be specific including amounts, types of food, etc.)
Sample Record		
8:30 am	Breakfast	1 ½ cup Chocolate Chex with ½ cup 2% milk
		1 cup regular coffee with 2 Tbsp half and half and 1 Tbsp sugar
		1 homemade cinnamon bun (about size of my fist)
		2 slices bacon
	Breakfast	
	Lunch	
	Dinner	
	Snack	
	Snack	
	Snack	
	Other	

Food Diary Day 3

Time of Day	Meal Eaten	Food Eaten (please be specific including amounts, types of food, etc.)
	Sample Record	
8:30 am	Breakfast	1 ½ cup Chocolate Chex with ½ cup 2% milk
		1 cup regular coffee with 2 Tbsp half and half and 1 Tbsp sugar
		1 homemade cinnamon bun (about size of my fist)
		2 slices bacon
	Breakfast	
	Lunch	
	Dinner	
	Snack	
	Snack	
	Snack	
	Other	