Pre Donation Nutrition Questionnaire

Date: ___________ Age: ___________ Gender: _______ Height: _______ Weight: _______

Pertinent Medical History: ________________________________________________________

Medications List: ________________________________________________________________

Any recent weight changes? ☐ Yes ☐ No  If so, check which one ☐ Gain ☐ Loss
If so, how many pounds: ________________________________________________________
Time frame of weight change: ___________________________________________________
Reason for weight change: ______________________________________________________

Have you ever seen a Dietitian or Nutritionist before or has your doctor ever advised you to follow a special diet? ☐ Yes ☐ No ___________________________________________________________

What type of diet do you follow at home? ___________________________________________

Are there any foods that you avoid? ☐ Yes ☐ No ______________________________________

How has your appetite been lately? ☐ good ☐ bad ☐ fair _____________________________

How many meals per day do you eat? _______________________________________________

Do you eat any snacks? ☐ Yes ☐ No __________________________________________________

Do you have any food allergies? ☐ Yes ☐ No __________________________________________

Do you have any chewing or swallowing problems? ☐ Yes ☐ No __________________________

Do you have any ongoing nausea, diarrhea, or constipation? ☐ Yes ☐ No _________________

Do you drink alcohol? ☐ Yes ☐ No  If so – what and how often? _________________________

Do you taken any nutritional supplements? ☐ Yes ☐ No  (ex: Boost, Ensure, Multi Vitamins, and Herbal Medications) _________________________________

Do you participate in regular physical activity? ☐ Yes ☐ No (If so what and how often) ______

Who is responsible for grocery shopping and cooking meals? __________________________

If you have any particular questions please contact the transplant dietitian at 860-545-4428.