TRANSPLANT PROGRAM
HARTFORD HOSPITAL

Patient Name_____

Patient DOB_____

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.