HOSPITAL STREET DOCTORS

Diet Record

Please complete all the boxes and bring the completed form to your appointment.

Personal details:

Today's date (dd/mm/yyyy)

☐ Mr ☐ Dr
☐ Mrs ☐ _____
☐ Miss

First name(s)

Surname

Date of birth (dd/mm/yyyy)

Height

Weight

How often, if at all, do you consume the following:

	Never	Infrequently	Sometimes	Regularly/daily	Frequently
bread	☐	☐	☐	☐	☐
coffee	☐	☐	☐	☐	☐
tea	☐	☐	☐	☐	☐
alcoholic drinks	☐	☐	☐	☐	☐
chocolate	☐	☐	☐	☐	☐
sugar (cane) brown	☐	☐	☐	☐	☐
oranges	☐	☐	☐	☐	☐
corn and corn products	☐	☐	☐	☐	☐
pork/bacon	☐	☐	☐	☐	☐
preserved meats	☐	☐	☐	☐	☐
milk	☐	☐	☐	☐	☐
cheese	☐	☐	☐	☐	☐
cakes or biscuits	☐	☐	☐	☐	☐
eggs	☐	☐	☐	☐	☐
potatoes	☐	☐	☐	☐	☐
beetroot or beet sugar (white)	☐	☐	☐	☐	☐
tomatoes	☐	☐	☐	☐	☐
cereals/breakfast foods	☐	☐	☐	☐	☐
fish	☐	☐	☐	☐	☐
beef	☐	☐	☐	☐	☐
lamb	☐	☐	☐	☐	☐
salt	☐	☐	☐	☐	☐
nuts	☐	☐	☐	☐	☐
soft drinks	☐	☐	☐	☐	☐
root vegetables	☐	☐	☐	☐	☐

Please answer the following:	Yes	No	
Is there any food that you eat at least once a day (or crave for)?	☐	☐	*If yes, please list*
Do you eat regularly?	☐	☐	*How many times per day do you eat?*
Is there any food you dislike?	☐	☐	*If yes, please list*
Is there any food that you avoid because it disagrees with you?	☐	☐	*If yes, please list*
Do you eat out?	☐	☐	*If yes, how often?*
When you were a child were there any foods you disliked, or felt ill after eating?	☐	☐	*If yes, please list*
Since your symptoms started, have you increased your intake of any food?	☐	☐	
Do traffic fumes upset you?	☐	☐	
Do crop sprays or pesticides affect you?	☐	☐	
Do gas fumes upset you?	☐	☐	
Do enclosed shopping areas affect you?	☐	☐	

Describe a typical day's diet

Breakfast	Tea	Snacks/other foods
Lunch	Dinner	