

NORTHERN MONTANA HOSPITAL  
DIABETES CARE SERVICES – NUTRITION HISTORY

Name \_\_\_\_\_

Diet changes since diagnosis \_\_\_\_\_

Do you skip any meals? \_\_\_\_\_ If so, please explain what meals and circumstances for not eating

How many times per week do you eat out? \_\_\_\_\_ What type of restaurants do you choose? \_\_\_\_\_

Who does the cooking and shopping in your household? \_\_\_\_\_

Do you read food labels when shopping? \_\_\_\_\_

What diet changes would you benefit from? \_\_\_\_\_

IT IS VERY IMPORTANT TO COMPLETE THE FOOD RECORD BELOW. PLEASE PRINT IN BLACK INK AND BRING WITH YOU TO YOUR FIRST APPOINTMENT. Try to eat as you typically would. **Write down everything you eat or drink. Indicate quantities as accurately as possible. Measure if you are not sure.**

MEAL	TIME	TYPICAL INTAKE
Breakfast		
Lunch		
Dinner		
Snacks		