CLAREMONT
Nursing & Rehabilitation Center

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DIETARY QUESTIONNAIRE: This questionnaire will help us learn your family member's food preferences and assure that your family member does not have many changes from their usual dining routine.

- Which foods are not usually eaten? (Please list specific dislikes.)

  Dairy: ____________________

  Meat: ____________________

  Fruit: ____________________

  Vegetables: ____________________

  Bread & Cereals: ____________________

- What is the preferred beverage with meals? (Please place an **X** beside those that apply.)

  ____ Coffee ____ Water ____ Tea ____ Juice ____ Other: ____________

- Usual weight in the past five years: ____________________

- Has weight gone up or down? ____ Up ____ Down ____ No Fluctuation

- By how many pounds? ____________________

- Are there any problems with eating? (Please place an **X** beside those that apply.)

  ____ Eats Slowly ____ Not Hungry ____ Nausea/Vomiting ____ Chewing Problems

  ____ Needs Assistance ____ Other: ____________________

- Is there anything special we should know about mealtime? ____________________

  ____

- How much fluid is taken per day? _________ cups

- Does your family member wear dentures? (Please place an **X** beside those that apply.)

  ____ No ____ Loose Dentures ____ Upper ____ Lower ____ Decayed/Missing Teeth