



Sydney Local Health District

Facility: ROYAL PRINCE ALFRED HOSPITAL

DIET HISTORY QUESTIONNAIRE

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date	You (or your child's) details			
	Height (cm)		Weight (kg)	

Record the typical meals, foods, and drinks you (or your child) eat in a week.
Include stocks, sauces, herbs, spices, butter, margarine and sugar.

Breakfast	
Morning Tea	
Lunch	
Afternoon Tea	
Dinner	
Supper	

COMMONLY EATEN FRUIT (list)	
-----------------------------	--

COMMONLY EATEN VEGETABLES (list)	
----------------------------------	--

This questionnaire was completed by:

Name (please print): _____ Signature: _____ Date: _____

BINDING MARGIN - NO WRITING

DIET HISTORY QUESTIONNAIRE

MR 070.010



Facility: ROYAL PRINCE ALFRED HOSPITAL

DIET HISTORY QUESTIONNAIRE

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Record the type and frequency of the below food/drink types each week.
Complete only those that apply.

Food/Drink <i>E.g. Soft drink</i>		Type & Frequency <i>E.g. Lemonade 1x per week</i>
Drink	Water	
	Tea (Normal/Decaf/Herbal)	
	Coffee (Regular/Decaf)	
	Milks / Soy or Rice Drink	
	Juice	
	Cordial	
	Soft Drink	
	Alcohol	
Other drinks e.g. sports/ protein/ energy		
Food	Cheese	
	Yoghurt	
	Crackers / Crispbreads	
	Cake / Biscuits	
	Chocolate	
	Nuts / Seeds	
	Lollies	
	Chewing gum / mints	
	Crisps / Chips	
	Dried Fruit	
Sandwich fillings e.g. spreads, meats, etc.		
Other	Spice, stock cube, sauces	
	Oil (specify)	
	Margarine (specify)	
	Eating Out / Takeaway	

BINDING MARGIN - NO WRITING

This questionnaire was completed by:

Name (*please print*): _____ Signature: _____ Date: _____



Facility: ROYAL PRINCE ALFRED HOSPITAL

DIET HISTORY QUESTIONNAIRE

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Have you (or your child) had any reactions and/or avoid particular foods or drinks?
Complete only those that apply.

Food Group	Specify Food	Symptom(s) of reaction	Currently avoiding completely	
			No	Yes
Bread/cereal/grains			<input type="checkbox"/>	<input type="checkbox"/>
Vegetables			<input type="checkbox"/>	<input type="checkbox"/>
Fruit			<input type="checkbox"/>	<input type="checkbox"/>
Dairy Products			<input type="checkbox"/>	<input type="checkbox"/>
Meat, fish & eggs			<input type="checkbox"/>	<input type="checkbox"/>
Sweets & snacks			<input type="checkbox"/>	<input type="checkbox"/>
Drinks			<input type="checkbox"/>	<input type="checkbox"/>
Alcoholic drinks			<input type="checkbox"/>	<input type="checkbox"/>
Other			<input type="checkbox"/>	<input type="checkbox"/>

What is your (or your child's) RESPONSE to the following foods?

	Ok	Dislike	Never Eat	Reactions (<i>list symptoms</i>)
Pears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Celery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cabbage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brussel Sprouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Galic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Leek	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shallot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Onions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Legumes / Lentils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

This questionnaire was completed by:

Name (*please print*): _____ Signature: _____ Date: _____

BINDING MARGIN - NO WRITING

05082025

DIET HISTORY QUESTIONNAIRE

MR 070.010



Facility: **ROYAL PRINCE ALFRED HOSPITAL**

DIET HISTORY QUESTIONNAIRE

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Are you (or your child) currently taking any medications? *Please list below.*

Name (as on the label)	Brand (as on the label)	Medicine strength (as on the label)	How many do you (your child) take a day?	How many days per week is this medicine taken?

Are you (or your child) currently taking any supplements? *Please list below.*

Name (as on the label)	Brand (as on the label)	Medicine strength (as on the label)	How many do you (your child) take a day?	How many days per week is this supplement taken?

Do any of the below smells, fumes or environmental chemicals make you (or your child) feel unwell?

	Not at all	Just a little	Pretty much	Very much	Symptoms
Perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deodorants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Scented toiletries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cleaning agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Laundry detergents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pool chlorine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insecticide sprays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cigarette smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Petrol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Car fumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

This questionnaire was completed by:

Name (*please print*): _____ Signature: _____ Date: _____

Clinician Reviewing Form: _____ Signature: _____

Designation: _____ Date: _____ Time: _____ : _____

BINDING MARGIN - NO WRITING