

# Eating Pattern Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please answer the following questions and check the appropriate boxes that most closely describe your eating patterns.

1. Do you follow a special diet?

- No    Diabetic    Low sodium  
 Low fat    Kosher    Vegetarian    Other

Give examples of what guidelines or diets, if any, you follow

\_\_\_\_\_

\_\_\_\_\_

2. Which do you regularly eat?

- Breakfast    Lunch    Brunch    Dinner

3. When do you snack?

- Morning    Afternoon    Evening    Late night  
 Throughout the day

What are your favorite snack foods?

\_\_\_\_\_

\_\_\_\_\_

4. Do you eat out or order food in?

- Yes    No

How often?

- Daily    Weekly    Monthly    Other

What kind of restaurant(s)/eating facilities?

\_\_\_\_\_

\_\_\_\_\_

What kinds of cuisine?

\_\_\_\_\_

\_\_\_\_\_

5. How is your food usually prepared? (check all that apply)

- Baked    Broiled    Boiled  
 Fried    Steamed    Poached    Other

6. How many times each day do you have the following food items?

a. Starch (bread, bagel, roll, cereal, pasta, noodles, rice, potato)

- Never    Less than 1    1-2    3-5    6-8    9-11

b. Fruit

- Never    Less than 1    1-2    3-5    6-8    9-11

c. Vegetables

- Never    Less than 1    1-2    3-5    6-8    9-11

d. Dairy (milk, yogurt)

- Never    Less than 1    1-2    3-5    6-8    9-11

e. Meat, fish, poultry, eggs, cheese

- Never    Less than 1    1-2    3-5    6-8    9-11

f. Fat (butter, margarine, mayonnaise, oil, salad dressing, sour cream, cream cheese)

- Never    Less than 1    1-2    3-5    6-8    9-11

g. Sweets (candy, cake, regular soda, juice)

- Never    Less than 1    1-2    3-5    6-8    9-11

7. What beverages do you drink daily and how much?

Water \_\_\_\_\_ times or glasses per day (8 oz)

Coffee \_\_\_\_\_ times or cups per day

Tea \_\_\_\_\_ times or cups per day

Soda \_\_\_\_\_ times or glasses per day (12 oz)

Alcohol \_\_\_\_\_ times or glasses per day (12 oz)

Other \_\_\_\_\_ times or glasses per day

Specify \_\_\_\_\_

8. Would you like to change your eating habits?

- Yes    No

Which habits would you like to change?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Adapted with permission from the Wellness Institute, Northwestern Memorial Hospital.*