University of Notre Dame: New Student-Athlete Nutrition Questionnaire

ND Identification: _____

Name: _____ **Sport:** _____ **Date:** _____
Phone: _____ **Email:** _____ **Year:** FR ◯ SO ◯ JU ◯ SE ◯ 5 th yr ◯

Height: _____ft _____in **Current Weight:** _____lbs **Desired Weight (if different):** _____ lbs

Have you experienced any recent weight changes (within last year)? Yes____ No____
If "Yes", how many pounds? ____ lbs lost/gained(circle one)
Identify time frame of gains/losses: _____
And were weight changes intentional or unintentional? Explain: _____

Have you ever experienced symptoms of dehydration (headache, dizziness, light-headedness, nausea, etc.)? Yes___ No___
If "Yes" do you do anything differently to avoid them now? Yes_____ No_____
If "Yes", explain: (ie: Gatorade, drink more, electrolyte pack)_____

Have you ever experienced muscle cramping as a result of exercise? Yes____ No_____

Have you ever had to seek medical attention during competition/practice? Yes ____ No_____
If "Yes", Explain: (i.e. IV fluids, cramping, weakness, etc) _____

Please indicate below any medications (prescriptions or over the counter), Supplements, Vitamins/Minerals you are currently taking?

Type: Supplement/Vitamin/Drug *"Vitamin C"*	**Brand Name** *"Nature Made"*	**Dosage** *"500mg"*	**Frequency** *"2 x day"*	**Why Do You Take It?**

Please understand that all supplements are to be approved by the sports nutritionist*

Has a doctor ever told you that you have any of the following?

___Iron Deficiency Anemia ___Stress Fracture ___Diabetes or hypoglycemia ____Thyroid Issues
___High Cholesterol ___High Blood Pressure ___Irritable Bowel Syndrome ____High Triglycerides

Females Only:
Do you consider your menstrual cycle regular? Yes____No____ **Do you have it every month?** Yes ___No____
If "No" to either questions above, have you seen a doctor and what was the outcome of your visit?
Are you taking oral contraceptives? Yes____ No_____
If "Yes", for how long?_____

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Dietary Practices: **Please Identify the frequency you consume the foods in the chart below.**

Food	***Daily***	***Few times per week***	***Never/Rarely***
Dairy (milk, cheese, yogurt)			
Red Meat			
Fish			
Eggs			
Fruit			
Vegetables			
Soft Drinks			
Fast Food			
Breakfast			

Do you have any known food allergies? Yes_____ No_____ *If yes, please circle and identify below*

Gluten ☐ Peanuts ☐ Eggs ☐ Soy ☐ Shellfish ☐ Dairy ☐ Other:

_____

Do you have any known food sensitivities? Yes_____ No_____

If "Yes", please Identify: _____

Do you follow any special dietary practices? *(ie vegetarian, Kosher diet, etc..)* Yes_____ No_____

If "Yes", please Explain:

Please identify any specific foods you avoid: _____

Please list any specific nutrition questions/concerns/goals you have (optional):

Would you like to be contacted by Notre Dame's Sports Dietitian(s) to schedule a meeting to review your performance nutrition goals? Yes_____ No _____