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Nutrition for Kids, Teens and Families.

FOOD LIKES/DISLIKES FORM

Name: _____ Patient Number: Office only
 Date: _____ Age:
 Referring Physician : _____ Referring Clinic:

DIRECTIONS: Please cross off foods which are disliked and circle foods which are liked (add any details in boxes):

Milk

Whole
 Skim
 Low fat
 Cheese
 Yogurt

Vegetables

Fresh
 Frozen
 Canned

Veg
 Details

Fruit

Citrus
 Juice
 Other

Fruit
 Details

Starch

Bread, rolls
 Cereal
 Rice, pasta, etc.
 Potatoes/French fries
 Crackers
 Muffins, pancakes
 Breading, stuffing
 Corn

Meat/Protein

Beef
 Pork
 Lamb, veal
 Cold cuts
 Hot dogs
 Fish, Shellfish
 Tuna
 Poultry
 Eggs
 Peanut Butter
 Nuts
 Organ meats
 Dry beans, peas
 Other

Fat

Butter, margarine
 Oils, shortening
 Sour Cream
 Cream cheese
 Mayo
 Salad dressing
 Gravy
 Sausage, bacon
 Salt pork
 Coffee creamer
 Other

Snacks/Sweets

Cake/pie
 Cookies
 Ice cream/sherbet
 Jello/pudding
 Donut/pastry
 Chips/pretzels
 Sugar/honey
 Candy/chocolate
 Syrup/jam/jelly

Alcohol

Beer
 Wine
 Liquor

Beverages/Misc.

Soup/stew
 Casseroles
 Ethnic foods
 Pizza
 TV dinners
 Tea/coffee/decaf.
 Fruit drink
 Water

PLEASE ADD ANY DETAILS IN BOX BELOW: