Short Food Frequency Questionnaire Form PDF

Basic Information

Name: ________________________ Age: ______ Gender: □ Male □ Female □ Other

Weight: _______ kg Height: _______ cm

Dietary Preferences & Restrictions

1. **Do you have any dietary restrictions? □ Yes □ No**
   If yes, specify: ________________
2. **Do you avoid any food groups? □ Yes □ No**
   If yes, specify: ________________
3. **How many times do you eat in a day? ________________**

Food Consumption Pattern

Food Item	Daily	Weekly	Occasionally	Never
Green Leafy Vegetables	☐	☐	☐	☐
Fruits	☐	☐	☐	☐
Whole Grains	☐	☐	☐	☐
Dairy Products	☐	☐	☐	☐
Fast Food	☐	☐	☐	☐

Other Questions

Copyright @ SampleForms.com

1. **Do you consume caffeinated drinks? □ Yes □ No**
   If yes, how often? _______________
2. **Do you drink alcohol? □ Yes □ No**
   If yes, how often? _______________

Signature & Date

Signature: _______________ Date: _______________

Copyright @ SampleForms.com