Nursing Nutrition Assessment

PATIENT INFORMATION

Name: _____ Age: _____

Gender

◯ Male ◯ Female ◯ Other

Date of Admission: _____ dd / mm / yyyy Medical Record Number: _____

CLINICAL INFORMATION

Diagnosis

Current Medical Condition

Allergies

ANTHROPOMETRIC MEASUREMENTS

Height: _____ Weight: _____

BMI (Body Mass Index)

% Ideal Body Weight: _____

DIETARY HISTORY

Food Preferences

Dietary Restrictions

Special Diets (e.g., vegetarian, gluten-free)

Nutritional Supplements

NUTRITIONAL INTAKE

Usual Daily Food Intake

Recent Changes in Appetite

Oral Intake Tolerance

Difficulty Swallowing

◯ Yes ◯ No

NUTRITIONAL RISK FACTORS

Unplanned Weight Loss

◯ Yes ◯ No

Chronic Illness

◯ Yes ◯ No

Recent Surgery

◯ Yes ◯ No

Gastrointestinal Disorders

Food Allergies: _____

Medication affecting Nutritional Status:

PHYSICAL ASSESSMENT

Muscle Wasting

◯ Yes ◯ No

Edema

◯ Yes ◯ No

Skin Integrity

Hair and Nail Condition

LABORATORY DATA

Albumin Level: _____ **Prealbumin Level:** _____

Hemoglobin Level: _____ **Total Lymphocyte Count:** _____

NUTRITIONAL GOALS

Short-term Goals

Long-term Goals

INTERVENTIONS

Diet Modification

Nutritional Counseling

Enteral Nutrition

◯ Yes ◯ No

Parenteral Nutrition

◯ Yes ◯ No

MONITORING AND FOLLOW-UP

Monitoring and Follow-up

EDUCATIONAL NEEDS

Nutritional Education for Patient and Family

Meal Planning and Preparation

Importance of Adequate Hydration

DOCUMENTATION

Documented Food and Fluid Intake

◯ Yes ◯ No

Changes in Nutritional Status

◯ Yes ◯ No

Collaborative Interdisciplinary Communication

FOLLOW-UP PLAN

Scheduled Follow-up with Dietitian: _____ Reassessment of Nutritional Status: _____

NURSING NOTES

Nursing Notes

Nurse's Name: _____ Date: _____ dd / mm / yyyy