Nutrition Assessment Form

PATIENT INFORMATION

Name: _____ Age: _____

Gender: _____

ANTHROPOMETRIC MEASUREMENTS

Height: _____ Weight: _____

Body mass index (BMI): _____

LIMB MEASUREMENTS

Upper leg length (L): _____ Upper leg length (R): _____

Upper arm length (L): _____ Upper arm length (R): _____

WAIST CIRCUMFERENCE

Specify below:

SKINFOLD MEASUREMENTS

Biceps: _____ Triceps: _____

Iliac chest: _____ Thighs: _____

Calf: _____ Subscapular: _____

Abdomen: _____ Chest: _____

TYPICAL DAILY FOOD INTAKE

Breakfast:

Lunch:

Dinner:

Snacks:

Fluid intake: _____ Meal frequency: _____

Dietary restrictions:

Supplement use:

Changes in appetite:

BIOCHEMICAL DATA

Blood glucose levels: _____ Serum albumin: _____

Hemoglobin: _____ Total cholesterol: _____

Serum iron: _____

Other relevant lab results:

PHYSICAL EXAMINATION AND CLINICAL PRESENTATION

Skin:

- [ ] Texture
- [ ] Color
- [ ] Wounds
- [ ] Pressure sores

Hair:

- [ ] Thin
- [ ] Brittle
- [ ] Shiny

Nails:

- [ ] Brittle
- [ ] Spoon-shaped
- [ ] Healthy

Eyes:

- [ ] Pale conjunctiva
- [ ] Healthy

Oral health:

- [ ] Dry lips
- [ ] Cracked
- [ ] Sores

Muscle wasting:

- ◯ Present ◯ Not present

Fluid retention (edema): _____

General appearance:

- [ ] Weakness
- [ ] Fatigue
- [ ] Other

NUTRITIONAL RISK FACTORS

Difficulty chewing or swallowing:

Gastrointestinal Issues:

Any relevant medical conditions affecting nutrition:

History of enteral nutrition or tube feeding:

MEDICAL HISTORY

Current medical conditions:

Medications and supplements:

Surgical history:

History of chronic illness:

Known nutritional deficiencies:

NUTRITIONAL NEEDS AND GOALS

Dietary reference intakes (DRI) goals: _____ Caloric needs: _____

Protein needs: _____ Fluid needs: _____

Other nutritional requirements: _____

Enteral/parenteral nutrition requirements:

ADDITIONAL NOTES

Specify below:

Practitioner name: _____

Practitioner signature:

Date: _____ dd / mm / yyyy