Nutrition Assessment Form

Name:_____ Date of Birth:_____

Height:_____ Current weight:_____ Usual weight:_____ Desired weight:_____

Reason for consult:_____

Current eating pattern:

Breakfast:_____

_____

_____

Lunch:_____

_____

_____

Dinner:_____

_____

_____

Snacks:_____

_____

Dentition: Good Missing teeth Partial Dentures

Chewing: Good with difficulty

Swallowing: Good Sometimes difficult Always difficult

Food Allergies/Intolerances:_____

Supplements: Vitamins, herbals, include protein bars, shakes or teas

_____

_____

Activity: Exercise or PT_____ type_____ How often:_____

Eating out (restaurants, fast foods): how often and what type:

_____

_____

Medications:_____
_____
_____

Current Lab values (if known) If you can, scan your labs and send:

Glucose_____ **A1c:** _____ **Albumin:**_____

BUN:_____ **Creatinine:** _____ **Sodium:**_____ **Potassium:**_____

Triglycerides:_____ **Cholesterol:**_____ **LDL:** _____ **HDL:** _____

Calcium: _____ **Phosphorus:** _____ **PTH:** _____ **Hgb:** _____

Appetite: Good Fair Poor Improving Declining No change

GI Symptoms: Nausea Vomiting Diarrhea Constipation Indigestion Hiccups Abdominal pain Altered taste

Cooking/shopping: Who performs these tasks?_____

Hospitalization recently?_____

If yes, for what and how long?_____

Diabetes?_____ **If yes, how often do you test blood glucose?**_____

Cardiovascular issues? Do you modify your diet? _____

If yes, how?_____

Other GI or health issue impacting your diet and or your nutrition?

_____
_____
_____