

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:	
Skinfold measurements	
Biceps:	Triceps:
Iliac crest:	Thighs:
Calf:	Subscapular:
Abdomen:	Chest:
Dietary habits and nutrient intake	
Typical daily food intake	
Breakfast:	Lunch:
Dinner:	Snacks:
Fluid intake:	Meal frequency:

Dietary restrictions (allergies, intolerances, preferences):**Supplement use (vitamins, nutritional supplements, etc.):****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:****Hair:**

- Texture Wounds
 Color Pressure sores

- Thin Brittle Shiny

Nails:**Eyes:**

- Brittle
 Spoon-shaped
 Healthy

- Pale conjunctiva
 Healthy

Oral health:	Muscle wasting:
<input type="checkbox"/> Dry lips Cracked Sores	<input type="checkbox"/> Present Not present
Fluid retention (edema):	General appearance:
	<input type="checkbox"/> Weakness Fatigue <input type="checkbox"/> Others, specify:
Nutritional risk factors	
Difficulty chewing or swallowing (dysphagia):	Yes No
Gastrointestinal Issues (nausea, vomiting, diarrhea):	Yes No
Any relevant medical conditions affecting nutrition:	
History of enteral nutrition or tube feeding:	Yes No
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 (if applicable):****Additional notes****Practitioner name:****Signature:****Date:**