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 chest:	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:
☐ Dry lips ☐ Cracked ☐ Sores	◯ Present ◯ Not present
Fluid retention (edema):	**General appearance:**
	☐ Weakness ☐ Fatigue ☐ 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:**