NUTRITIONAL EVALUATION

History and Data Collection

Date of Admission: / / Age: 
Diagnosis: 
Diet Order: 
Allergies: 

PHYSICAL CHARACTERISTICS

Sex: [ ] M [ ] F 
Height: ________ Weight: ________ Usual weight: ________ 
BMI: ________ IBW: ________ Adjusted body weight: ________ 
Amputation: [ ] No [ ] Yes (if yes, specify body part and adjust IBW) __________________________________________________
Recent weight change (specify): ________________________________________________________________________________

ENERGY NEEDS

Needs ________ cal ________ gm prot ________ mL fluid 
calculated by __________________________________________ formula/method

DENTAL STATUS

Own teeth: [ ] Yes [ ] No [ ] Decay [ ] Tooth loss [ ] Gum Disease [ ] No teeth [ ] Mouth pain, specify 
[ ] Dentures: [ ] Upper Fit ________ [ ] Lower Fit ________ [ ] Partial: [ ] Upper Fit ________ [ ] Lower Fit ________ [ ] Will not wear dentures/partials

EATING ABILITY

[ ] Self-help device needed, type ____________________ [ ] Chewing problems
[ ] Swallowing problems ____________________
Tube Fed: [ ] Yes [ ] No If yes, current order: [ ] Pump [ ] Gravity [ ] Bolus 
Formula provides ________ cal/day ________ gm prot/day ________ mL fluid/day 
Does feeding provide 100% USRDA for vitamins/minerals as ordered? [ ] Yes [ ] No If no, ________%
Flush orders: ____________________
Tolerant of tube feeding? [ ] Yes [ ] No If no, state probable cause: ____________________
Ability to return to oral food intake: ____________________

PHYSICAL/MENTAL LIMITATIONS

[ ] Paralysis [ ] Upper limb immobility [ ] Aphasia [ ] Contractures [ ] Confused [ ] Combative [ ] Non-responsive [ ] Disoriented
[ ] Alert [ ] Language barrier Ambulation: [ ] Independent [ ] With assist [ ] Wheelchair [ ] No ambulation [ ] Paces
[ ] Ambulation (Other) ____________________ Comments: ____________________

CLINICAL OBSERVATIONS

(See Admission Nursing Assessment and check all that apply): [ ] Edema [ ] Diarrhea [ ] Constipation [ ] Vision impairment
[ ] Glasses [ ] Hearing aid: [ ] L [ ] R [ ] Poor appetite [ ] Vomiting [ ] Nausea Skin intact: [ ] Yes [ ] No If no, explain ____________________
Comments: ____________________

APPLICABLE MEDICATIONS (specify type and frequency)

<table>
<thead>
<tr>
<th>TYPE</th>
<th>DRUG</th>
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<tbody>
<tr>
<td>Vitamin/Mineral Supplement(s)</td>
<td>Antacids</td>
<td>Antipsychotics</td>
<td>Oral Contraceptives</td>
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<tr>
<td>Antibiotics</td>
<td>Anti-inflammatory</td>
<td>Diuretics</td>
<td>Antihistamines</td>
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<tr>
<td>Herbal Supplements</td>
<td>Appetite Stimulant</td>
<td>Potassium (K+)</td>
<td>Anticonvulsants</td>
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<tr>
<td>Diuretics</td>
<td>Anti-nausea</td>
<td>Psychotropic Drugs</td>
<td>Antidepressants</td>
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<tr>
<td>Diuretics</td>
<td>Oral Agents</td>
<td>Cardiac Glycosides</td>
<td>Anticoagulants</td>
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<tr>
<td>Potassium (K+)</td>
<td>Nausea</td>
<td>Laxatives</td>
<td>Antiepileptics</td>
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Name–Last First Middle Attending Physician Room/Bed Record No.
NUTRITIONAL EVALUATION
History and Data Collection

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<tr>
<th>TEST</th>
<th>LAB TEST</th>
<th>TEST RESULTS</th>
<th>WITHIN NORMAL</th>
<th>ABOVE NORMAL</th>
<th>BELOW NORMAL</th>
<th>INTERVENTIONS</th>
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FOOD PREFERENCES/INTOLERANCES

Location of meals:  
- Dining room; specify
- Room; specify

Appetite:  
- Good
- Fair
- Poor

Past food restrictions:  
- Salt
- Sugar
- None
- Other

Food dislikes/intolerances:

Food preferences:

Ethnic/Religious food preferences:

SOURCE OF INFORMATION (check all that apply)

- Resident
- Family member(s)
- Chart
- Nursing staff

Interviewed by ___________________________ Date: ______/_____/_____

NUTRITIONAL CARE PROCESS (be sure to include your signature, title and date)

Signature: ___________________________ Date: ______/_____/_____

NUTRITIONAL EVALUATION

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