# UNIVERSITY OF SOUTH ALABAMA

COLLEGE OF NURSING
OUR NEIGHBORHOOD HEALTHCARE CLINIC

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## Nutrition Assessment Form

Name:_____ DOB:_____ Date:_____
Referring Healthcare Provider:_____

**Medical/Social History:**
Reason for nutritional consult:_____
Current diagnosis, if applicable:_____
Current Medications: _____
_____
Medication Allergies: _____
Diagnosed Medical Conditions/Diseases: _____
_____
Family History of Disease: _____
_____
Recent Laboratory Tests: Blood Glucose _____ Hb A1c _____ Total Cholesterol _____
HDL _____ LDL _____ TG _____ BP _____
Height: _____ Current Body Weight: _____ Age: _____
Usual Body Wt: _____ ( highest _____ at age _____ ) ( lowest _____ at age _____ )
Smoker: _____ No _____Yes. If yes, how many packs per day per years _____ Have you ever attempted to quit smoking ___ No ___ Yes Do you have an interest in quitting?
_____
Alcohol Use: _____Yes, _____No How much per day _____ How many years? _____
Are you physically active most days of the week: _____ Yes _____ No Type: _____
_____

*For Office Use Only:*
Measured Height: _____
Measured Weight: _____
BMI: _____
Waist Circumference: _____

**Diet History:**
Vitamin and mineral supplements: _____
Weight loss, herbal or sports supplements: _____
Food allergies: _____
Food dislikes: _____
Describe your usual eating patterns:

How often do you eat out at restaurants? Consume fast food?

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Describe your typical eating environment ( e.g. alone, with a spouse/roommate, car, desk, t.v., etc…):

What is your primary goal that you wish to accomplish with nutritional counseling?

**Diet Recall:**

| ***Food Groups*** | ***Servings/day*** | ***Servings/week*** |
|---|---|---|
| | | |
| Breads, cereals, pasta, rice, corn, other grains | | |
| Fruits | | |
| Non-starchy vegetables such as broccoli, carrots, salad | | |
| Milk, cheese, yogurt | | |
| Meat, poultry, fish and eggs | | |
| Nuts and peanut butter | | |
| Beans, peas, lentils, tofu | | |
| Fats such as Oils, butter, salad dressings, gravy | | |
| Fried, Salty foods such as chips | | |
| Dessert foods | | |
| | | |
| ***Products*** | ***Servings/day*** | ***Servings/week*** |
| | | |
| Sweet beverages such as soda or fruit drinks | | |
| 100% fruit juice | | |
| Alcohol | | |
| Water | | |
| Caffeinated beverages such as coffee, tea, energy | | |
| drinks | | |
| Sports products such as drinks or bars | | |
| | | |
| ***Behaviors Past or Present*** | | |
| | | |
| *Behavior* *Yes* *No* | *Frequency* | *Most recent* |
| | | |
| Count calories | | |
| Count fat grams | | |
| Dieting | | |
| Diet pills | | |
| Binge eating | | |
| Restrictive eating | | |
| Fluid restriction | | |
| Discomfort with body size | | |
| Other | | |

_____ _____

**Emily R. Beaird MS, RD, LD, CHES, CDE** **Date**