Lexington Clinic

Medical Nutrition Therapy Services
1221 South Broadway | Lexington, KY 40504
Phone: 859.258.4032

NUTRITION ASSESSMENT PATIENT FORM

Name _____

Race ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other _____

Preferred Language _____ **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How many people live with you? _____ Adults _____Children

Education Level ☐ High School Diploma ☐ Associate's Degree ☐ Bachelor's Degree
☐ Master's Degree ☐ PhD ☐ Other _____

Occupational Status ☐ Professional ☐ Manual Labor ☐ Retired ☐ Unemployed ☐ Student ☐ Disabled

How many hours per week are you involved in work/school activities?

☐ Less than 10 hours ☐ 11 - 20 hours ☐ 21 - 30 hours ☐ 31 - 40 hours ☐ More than 40 hours

How do you learn best?

☐ Individual Instruction ☐ Group Instruction ☐ Reading Materials ☐ Video

Do you have any problems with the following?

Seeing ☐ Yes ☐ No **Hearing** ☐ Yes ☐ No **Reading** ☐ Yes ☐ No

MEDICAL HISTORY

List any medical conditions you are currently being treated for (ex. diabetes, hypertension)

_____

_____

_____

_____

Do you use tobacco? ☐ Yes ☐ No **If yes, how much?** _____ **# of years?**_____

Do you drink alcohol? ☐ Yes ☐ No **If yes, what type?** _____ **# of drinks per week?** _____

Please list any medications you are currently taking

Name of Medication	Reason	Dose	Times Taken

Compared to others your age, how would you say your health is?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

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NUTRITION ASSESSMENT PATIENT FORM *(continued)*

NUTRITION

Do you currently pay attention to your food choices or follow an eating plan? ☐ Yes ☐ No

What type of special meal plan do you follow?_____

_____

Has your weight changed in the past year? ☐ Yes ☐ No **If yes, how much?** Gained _____ Lost _____

What is your desired body weight? _____

Have you ever participated in a weight loss program? ☐ Yes ☐ No

If yes, please explain _____

_____

Do you currently take any vitamin/mineral/herbal supplement? ☐ Yes ☐ No

If yes, please list _____

_____

Please list any cultural diet influences that you currently follow

_____

_____

Do you have any trouble chewing/swallowing foods? ☐ Yes ☐ No

Who prepares your meals daily? _____

How many times per day do you eat? _____

How many times per week do you eat out? _____ **Where?** _____

What would you say is the biggest challenge that you have with your diet?

_____

_____

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NUTRITION ASSESSMENT PATIENT FORM *(continued)*

24 HOUR DIET RECALL

Please list everything that you remember eating in the past 24 hours. Please list time, food and the amount that you ate.

Breakfast (time:)	Lunch (time:)	Dinner (time:)	Snacks (time:)

PHYSICAL ACTIVITY

Are you currently involved in an activity/exercise program? ☐ Yes ☐ No

If yes, please describe _____

_____

How many minutes do you spend per day participating in exercise? _____

How would you rate your physical activity level?

☐ Inactive: *No regular physical activity*
☐ Light: *No regular physical activity, with 3-4 hours of walking or standing each day*
☐ Moderate: *Occasional weekend physical activity such as housework/yard work*
☐ Heavy: *Consistent physical activity such as lifting, heavy construction or active sports like cycling or jogging, 3 times per week*
☐ Vigerous: *Intense physical activity for at least 45 minutes greater than 4 times per week*

Patient Signature _____ Date _____