

مستشفى مارينا الاهلي

Patient ID Label

Nutritional Assessment

Marital status: _____

Diagnosis: _____

Height / length : _____

Weight: _____

BMI : _____

Weight for age: _____ length for age _____ head circumference for age: _____

Medical history:

- | | |
|--|--|
| <input type="radio"/> High cholesterol | <input type="radio"/> Type 2 diabetes |
| <input type="radio"/> Type 1 diabetes s | <input type="radio"/> Allergy |
| <input type="radio"/> High blood pressure | <input type="radio"/> PCOS |
| <input type="radio"/> Hyper/ Hypo Thyroidism(tick one) | <input type="radio"/> IBS/IBD |
| <input type="radio"/> Anemia | <input type="radio"/> High uric acid |
| <input type="radio"/> Hypertriglyceridemia | <input type="radio"/> Constipation / diarrhea (tick one) |
| <input type="radio"/> G6PD | <input type="radio"/> Asthma |
| <input type="radio"/> Renal diseases | <input type="radio"/> Liver diseases |
| <input type="radio"/> Malnutrition | |

Other: _____

Surgery: _____

Problems that interfere ability to eat: _____

Food allergies / intolerance: _____

Dislikes: _____

Medications / nutritional supplements: _____

Diet (home): _____ Diet (hospital) : _____

Nutritional plan:

Type of feeding:

- Oral feeding
- Tube feeding(nasogastric / gastrostomy)
- Total Parenteral Nutrition(TPN)

Oral feeding

Kcal/day _____ Fat _____ CHO _____ Protein _____

Milk and milk substitutes _____ Fluids _____

Minerals (Na _____ /K _____ /Ca _____ /Fe _____)

Tube feeding:

Kcal/day _____ Type of formula (ready to use / kitchen formula)

Volume of formula / day: _____ Number of meals/day: _____ Volume / meal: _____

Notes: _____

Total Parenteral Nutrition (TPN)

Kcal/day _____ Type _____

Notes _____

Assessment done by _____