This Page Is For Office Use Only:

Nutritional Assessment and Care Plan

Referring MD:

Diagnoses/ICS-9 Codes:

Height: ____**ft.** ____ **in. Weight:** _____**# Recommended Weight:**_____**-**_____ **# BMI:** _____ **Kg/m^2**

Estimated Daily Energy Expenditure: _____ **Kcal. Patient's Daily Calorie Goal:** _____

Problems: Nausea/Vomiting Constipation/Diarrhea Swallowing/Chewing GERD

Lab Values: Total Chol: LDL: HDL: Trigly: BUN: Albumin:
Hemoglobin A1$_c$:

Other:

Diet:

Date	Weight	Change	Comments:

Stanford Hospital and Clinics Nutrition Profile

Name: _____ _____ Date: _____
(Last) (First)

Address:_____

Daytime Telephone: ( )_____ Occupation: _____

Do you normally pay an insurance Co-payment for medical appointments? _____

Primary Care Doctor's Name and Location:

_____

Have you ever had? High Cholesterol Yes/No High Blood Sugar Yes/No High Blood Pressure Yes/No

List any medications, vitamins, minerals, herbs and nutritional supplements that you take:

_____

_____

_____

Age: ___ Height: __ft. ___in. Weight: _____ What is a realistic, healthy weight for yourself?: _____

How has your weight changed in the past two years? _____

Who prepares your meals at home? _____

What percent of meals that you eat are prepared at your home? _____

Please indicate your typical intake of the following beverages:

Beverage	How Often? (Daily, Weekly, Monthly, Yearly)	How Many Cups or Ounces?
Whole milk		
Low fat, 2% or reduced fat		
Nonfat, skim, or 1% milk		
Juice, fruit drinks, Kool-Aid		
Regular soda		
Wine		
Beer		
Liquor		
Coffee, hot tea, iced tea		
What do you put in your coffee or tea? Sugar Milk Cream Sugar Substitute		

What types of exercise do you do regularly and how much time each week do you spend doing them?

Activity or Exercise	Times per Week	Minutes per Activity

How can we be of help to you?_____

_____

Please record your food intake for two typical days

Food Intake Record Day 1

Date:

MEAL	FOOD	AMOUNT EATEN
BREAKFAST:		
SNACK & BEVERAGES:		
LUNCH:		
SNACK & BEVERAGES:		
DINNER:		
SNACK & BEVERAGES:		
Exercise:	**Type of Exercise:**	**Number of Minutes:**

Food Intake Record Day 2

Date:

MEAL	FOOD	AMOUNT EATEN
BREAKFAST:		
SNACK & BEVERAGES:		
LUNCH:		
SNACK & BEVERAGES:		
DINNER:		
SNACK & BEVERAGES:		
Exercise:	**Type of Exercise:**	**Number of Minutes:**