GOVERNMENT OF MEGHALAYA
HEALTH AND FAMILY WELFARE DEPARTMENT

Nutrition Assessment Form

Name of the patient.....

Age.....Gender.....

Patient ID..... Bed No.....

Diagnosis.....

Department.....Date and Time of

Assessment.....

Anthropometric Measurements	
Height (cm)	
Weight (kg)	
Body Mass Index (kg/m^2)	
Mid-Upper Arm Circumference (MUAC)	
Weight-for-Height Percentile (Children)	
Weight-for-Age Percentile (Children)	
Dietary History	
24-Hour Dietary Recall (Type & Quantity)	
Food Preferences (Veg/Non-Veg/Other)	
Dietary Restrictions (Allergies/Cultural or medical restrictions)	
Frequency (Number of meals/ Snacks per day)	
Clinical Information	
Medical History (NCDs/Communicable disease)	
Current medication	
Symptoms	
Biochemical Data	
Hemoglobin	
Serum Albumin	
Blood Glucose	
Lipid Profile	
Vitamin Level (Vitamin D, B12, etc.)	
Physical Activity	
Activity Level (Sedentary, Moderate, Active)	
Impact on Nutrition (Mobility issues affecting intake)	

Dietary Advice:

(Signature)

(M.O. In-Charge/Staff Nurse/ Nutritionist/Dietician)