

# Transplant Nutrition Assessment Form

**Please fill out this questionnaire prior to your appointment.** This information will contribute to the development of nutrition therapy based on your needs and current lifestyle habits. Please feel free to include any additional information you feel might be relevant to your current situation.

## Personal Information

Name	Gender	Age
Height	Dry Weight	

## Medical History

Please provide information about your past medical history. Check all those that may apply.

- |  |                                    |  |
|--|------------------------------------|--|
| <input type="radio"/> Diabetes               | <input type="radio"/> Hypertension | <input type="radio"/> High Cholesterol |
| <input type="radio"/> Cardiovascular Disease | <input type="radio"/> Cancer       | <input type="radio"/> Kidney Disease   |
| <input type="radio"/> Neurological Condition | <input type="radio"/> Osteoporosis | <input type="radio"/> Liver Disease    |
| <input type="radio"/> Other _____            |                                    |  |

## Nutrition Information

Do you have any trouble chewing or swallowing?  Yes  No

Do you have any food allergies or intolerances?  Yes  No

If yes, please list:

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Do you take any vitamin, mineral, or herbal supplements?  Yes  No

If yes, please list all such medication:

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Please list your current exercise/physical activity patterns:

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Do you follow a special diet?  Yes  No

If yes, please describe:

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Please remember to bring your **dialysis lab report card** with you to your appointment.