Living Donor 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 | Weight

Medical History

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

- ❍ Diabetes
- ❍ Cardiovascular Disease
- ❍ Neurological Condition
- ❍ Other_____
- ❍ Hypertension
- ❍ Cancer
- ❍ Osteoporosis
- ❍ High Cholesterol
- ❍ Kidney Disease
- ❍ Liver Disease

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:

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

If yes, please list all such medication:

Please list your current exercise/physical activity patterns:

Do you follow a special diet? ❍ Yes ❍ No

If yes, please describe: