(See DD Form 2005 for Privacy Act Statement)

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

NUTRITION ASSESSMENT

OTSG APPROVED *(Date)*

S:

O: Age	Sex ☐ Male ☐ Female	Height	Weight	Palb	Alb	N/A

Labs

Significant meds

PMH/PSH

DX

A: ☐ Calorie Malnutrition ☐ Protein malnutrition ☐ Overweight (BMI 27-29.9) ☐ Obesity I (BMI 30-34.9) ☐ Obesity II (BMI 35-39.9) ☐ Obesity III (BMI ≥40)

Dietary recall: ☐ Breakfast ☐ Snack ☐ Lunch ☐ Snack ☐ Dinner ☐ Snack

Education provided ☐ Yes ☐ No

Suspected compliance ☐ Good ☐ Fair ☐ Poor

P:

☐ F/U needed - will schedule appointment ☐ Recommended class participation _____

☐ Please check _____ labs prior to follow up

☐ Diet modification records recommended:

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT