



Patient record: Nutrition

Blank form to fill in by hand.

Clinic

Doctor

Date

____ / ____ / ____
dd/mm/yyyy

Essentials

First name

Last name

Date of birth

____ / ____ / ____
dd/mm/yyyy

Place of birth

Nationality

Profession

Phone number

Email

Address

Gender

☐ Female ☐ Male ☐ Non binary ☐ Prefer not to say

1. Goal

Primary goal

☐ Weight loss ☐ Weight gain ☐ Weight maintenance ☐ Sports performance ☐ Disease management

Motivation and expectations

2. Anthropometrics

Height

Measurements

Date	Weight	BMI	Waist	Body fat	Muscle mass

3. Medical History

Diabetes or insulin resistance? ☐ Yes ☐ No

If yes, give details: _____

Thyroid disease? ☐ Yes ☐ No

If yes, give details: _____

Gastrointestinal problems? ☐ Yes ☐ No

If yes, give details: _____

Food allergies or intolerances? ☐ Yes ☐ No

If yes, give details: _____

Eating disorders? ☐ Yes ☐ No

If yes, give details: _____

Medications and supplements

4. Dietary Habits

24-hour dietary recall

Meal	Foods	Portion

Glasses of water per day

Physical activity

☐ Sedentary ☐ Light ☐ Moderate ☐ Intense

Other habits

5. Nutrition Plan

Recommended daily calories

Meal plan

Recommendations and supplements

6. Consent

Informed consent

1. I have been informed in an understandable way about my diagnosis, the purpose of the proposed treatment, the procedures that may be performed, reasonable alternatives, expected benefits, limitations and possible risks.
2. I have been informed that the outcome of treatment cannot be guaranteed absolutely and that additional procedures, check-ups or treatment may be needed depending on the clinical situation.
3. I have had the opportunity to ask questions, and I declare that the answers I received were sufficient for my decision.
4. I authorize the nutritionist and clinical staff to perform the agreed treatment and clinically necessary supporting procedures within the treatment plan discussed with me.
5. I have been informed that I have the right to refuse the treatment or to withdraw this consent at any time. Withdrawal does not affect procedures performed before it.

Patient or Legal Representative Signature

Doctor Signature

Date:

Date:

Signature

Date

____ / ____ / ____
dd/mm/yyyy