Please mark the correct boxes

# PATIENT SHEET
## SHEET 3a

Date
Center-Code
Unit-Code

**Patient number** **Patients Initials**

**1. What are your typical dietary habits? (mark all that apply)**

- ☐ No special dietary habits
- ☐ I am vegetarian
- ☐ I adhee to a vegan diet
- ☐ I eat gluten-free diet
- ☐ I avoid added sugars
- ☐ I avoid carbohydrates
- ☐ I eat a low fat-diet
- ☐ I am lactose intolerant
- ☐ Other special diet due to intolerances/allergies
- ☐ Other

**2. Where did you live before your current hospital admission?**

- ◯ At home
- ◯ In a nursing home or other live-in facility
- ◯ I was transferred from another hospital
- ◯ Other

**3. In general, are you able to walk?**

- ◯ Yes
- ◯ Yes, with someone's help
- ◯ Yes, independently using a cane, walker, or crutches
- ◯ No, I have a wheelchair
- ◯ No, I am bedridden

**4. In general, how would you say your health is?**

◯ Very good ◯ Good ◯ Fair ◯ Poor ◯ Very poor

**5. Over the last 12 months prior to your current hospital admission approximately…**

… how many times have you seen a doctor? ____ times

… how many times have you been admitted to the hospital (Emergency room, any ward)? ____ times

… how many nights in total have you spent in hospital? ____ nights

**6. How many different medications do you take routinely each day (prior to hospitalisation)?**

- ◯ 1-2
- ◯ 3-5
- ◯ More than 5
- ◯ None
- ◯ I do not know

**7. Do you have health insurance?**

- ◯ Yes, private insurance only
- ◯ Yes, public insurance only
- ◯ Yes, both
- ◯ No
- ◯ I prefer not to answer

**8. What was your weight 5 years ago?** ____ lb. ◯ I do not know

**9a. Have you lost weight within the last 3 months?**

- ◯ Yes, intentionally
- ◯ Yes, unintentionally
- ◯ No, my weight stayed the same
- ◯ No, I gained weight
- ◯ I do not know

**9b. If yes, how many kg did you lose?** ____ lb. ◯ I do not know

**10. Did you know about your hospitalisation two days before admission?** ◯ Yes ◯ No

**11. Please indicate if you …**

| | | | |
|---|---|---|---|
| ... were weighed at admission | ◯ Yes | ◯ No | ◯ I do not know |
| ... were informed about your nutrition status | ◯ Yes | ◯ No | ◯ I do not know |
| ... were informed about nutrition care options | ◯ Yes | ◯ No | ◯ I do not know |
| … received special nutrition care | ◯ Yes | ◯ No | ◯ I do not know |

**Please continue with Sheet 3b**

**Please mark the correct boxes that apply to you**

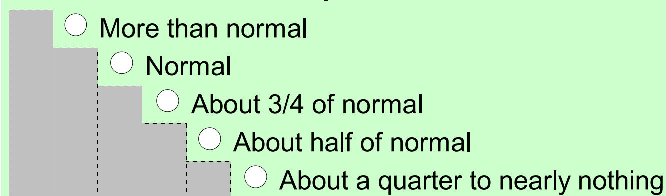
nutritionDay worldwide

# PATIENT SHEET
## SHEET 3b

| Date | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Center-Code | | | | |
| Unit-Code | | | | |

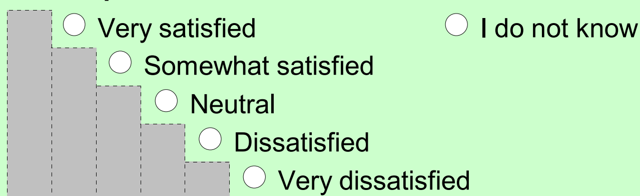
**Patient number** ☐☐☐ **Patients Initials** ■

**12. How well have you eaten in the week before you were admitted to the hospital?**



- ◯ More than normal
- ◯ Normal
- ◯ About 3/4 of normal
- ◯ About half of normal
- ◯ About a quarter to nearly nothing

**13. In general, how satisfied are you with the food at the hospital?**



- ◯ Very satisfied
- ◯ Somewhat satisfied
- ◯ Neutral
- ◯ Dissatisfied
- ◯ Very dissatisfied
- ◯ I do not know

**14. Did you get any help with eating TODAY?**

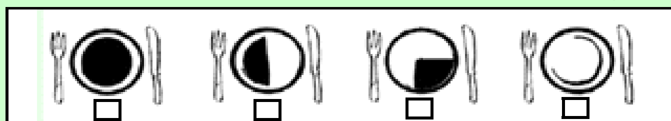
- ◯ Yes, from family or friends
- ◯ Yes, from hospital staff
- ◯ No

**15. Were you able to eat without interruption TODAY?**

- ◯ Yes
- ◯ No

**16a. Please indicate how much hospital food you ate for lunch or dinner TODAY:**

**about all** **1/2** **1/4** **nothing**



**16b. The portion size of the meal I ordered TODAY was…**

- ◯ standard
- ◯ smaller
- ◯ larger
- ◯ I do not know

**17. If you did not eat everything of your meal, please tell us why: (mark all that apply)**

- ☐ I did not like the type of food offered
- ☐ I did not like the smell/taste of the food
- ☐ The food did not fit my cultural/religious preferences
- ☐ The food was too hot
- ☐ The food was too cold
- ☐ Due to food allergy/intolerance
- ☐ I was not hungry at that time
- ☐ I do not have my usual appetite
- ☐ I have problems chewing/swallowing
- ☐ I normally eat less than what was served
- ☐ I had nausea/vomiting
- ☐ I was too tired
- ☐ I cannot eat without help
- ☐ I was not allowed to eat
- ☐ I had an exam, surgery, or test and missed my meal
- ☐ I did not get requested food

**18. Enter the number of glasses/cups of the drinks you consumed in the last 24 hours**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Water | ☐ | Coffee | ☐ | Fruit juice | ☐ | Nutrition drink |
| ☐ | Tea | ☐ | Milk | ☐ | Soft drinks | ☐ | Other |

**19a. Did you eat any food apart from hospital food TODAY?** ◯ Yes ◯ No

**19b. If yes, what did you eat?**

- ☐ Sweet snacks
- ☐ Salty snacks
- ☐ Homemade food
- ☐ Fruits
- ☐ Dairy products
- ☐ Food delivered/restaurant
- ☐ Sandwich
- ☐ Other

**20. How has your food intake changed since your hospital admission?**

◯ Increased ◯ Decreased ◯ Stayed the same ◯ I do not know

**21. TODAY I feel…**

- ◯ Stronger than at admission
- ◯ Weaker than at admission
- ◯ Same as at admission
- ◯ I was admitted today
- ◯ I do not know

**22. Can you walk without assistance TODAY?**

- ◯ Yes
- ◯ No, only with assistance
- ◯ No, I stay in bed

**23. Did anyone help you complete this questionnaire?** ◯ Yes ◯ No

**THANK YOU!**