CALORIE COUNT FORM

PT NAME: ____________________

Please record all foods and beverages consumed by patient including the amounts using percentages. Supplements and snacks should also be documented. Please include any food consumed by the patient from outside the hospital as well.

Day 1 Date: _______	Breakfast	Lunch	Dinner	Snacks
Day 2 **Date:** _______	**Breakfast**	**Lunch**	**Dinner**	**Snacks**
Day 3 **Date:** _______	**Breakfast**	**Lunch**	**Dinner**	**Snacks**

Contact Dietitian at ____________________ with questions.