Mini Nutritional Assessment (MNA)

Surname: Name:

Gender: Age: Weight, kg: Height, cm: Date:

Answer the first part of the questionnaire by assigning the appropriate score to each question. Add up the screening assessment score and, if the result is equal or less than 11, complete the questionnaire to obtain a nutritional status assessment.

Screening

A **Do you have a loss of appetite? Have you eaten less in the last 3 months? (digestive problems, dysphagia)**
0= severe reduction in food intake
1= moderate reduction in food intake
2= no reduction in food intake ☐

B **Weight loss**
0= weight loss > 3 kg
1= does not know
2= weight loss between 1 and 3 kg
3= no weight loss ☐

C **Mobility**
0= from bed to armchair
1= independent at home
2= leaves the house ☐

D **In the last 3 months: acute illnesses or psychological stress?**
0= yes 2=no ☐

E **Neuropsychological problems**
0= dementia or severe depression
1= moderate dementia
2= no psychological problems ☐

F **Body Mass Index (BMI)**
0= BMI < 19
1= BMI between 19 and 21
2= BMI between 21 and 23
3= BMI > 23 ☐

Screening assessment ☐☐
(max.14 points)

12-14 points: Normal nutritional status
8-11 points: At risk of malnutrition
0-7 points: Malnourished

For a more in-depth assessment, continue with the questions **G-R**

G **Does the patient live independently at home?**
0 = no 1= yes ☐

H **Does the patient take more than 3 medicines per day?**
0= yes 1 = no ☐

I **Presence of bedsores or skin ulcers?**
0= yes 1 = no ☐

J **How many full meals does the patient eat per day?**
0 = 1 meal
1= 2 meals
2= 3 meals ☐

K **Does the patient consume:**
- Dairy products at least once a day — yes ☐ no ☐
- Eggs or legumes once or twice a week — yes ☐ no ☐
- Meat, poultry or fish once a day — yes ☐ no ☐

0.0 = 0 or 1 “yes”
0.5 = 2 “yes”
1.0 = 3 “yes” ☐.☐

L **Does the patient consume fruit or vegetables at least twice a day?**
0 = no 1 = yes ☐

M **How many glasses does the patient consume per day?**
0.0 = less than 3 glasses
0.5 = from 3 to 5 glasses
1.0 = more than 5 glasses ☐.☐

N **How does the patient eat?**
0 = needs assistance
1 = independently with difficulty
2 = independently without difficulty ☐

O **Does the patient consider themselves well-nourished? (do they have nutritional problems?)**
0 = severe malnutrition
1 = moderate malnutrition or does not know
2 = no nutritional problems ☐

P **Does the patient consider their health to be better or worse than other people of their age?**
0.0 = less good
0.5 = does not know
1.0 = the same
2.0 = better ☐.☐

Q **Brachial circumference (BC, cm):**
0.0 = CB < 21
0.5 = CB ≤ 21 CB ≤ 22
1.0 = CB > 22 ☐.☐

R **Calf circumference (CC, cm)**
0 = CP < 31
1 = CP ≥ 31 ☐

Overall assessment (max. 16 points) ☐☐.☐
Screening total assessment (max. 30 points) ☐☐.☐
Nutritional status assessment ☐☐.☐

24-30 points ☐ normal nutritional status
17-23.5 points ☐ risk of malnutrition
less than 17 points ☐ poor nutritional status