Advanced Radiology Services PC

Feeding Tube Questionnaire

Patient Name: ____

Date of Birth: ____________________

Today's Date: ____________________

Have you sustained recent weight loss: ☐ Yes ☐ No

If yes, how much weight have you lost: ______ lbs

If yes, over what period of time: ___________

If yes, was the weight loss intentional: ☐ Yes ☐ No

When did you start to notice this weight loss - Date: ____________

Is the weight loss related to a cancer diagnosis: ☐ Yes ☐ No

If yes, have you had treatment for the cancer: ☐ Yes ☐ No

If yes, what type of treatment have you had: ☐ Chemotherapy ☐ Radiation

Please give us a brief history of this condition:

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Are you currently or have you seen a Nutritionist or Dietitian: ☐ Yes ☐ No

Are you currently taking any dietary supplements: ☐ Yes ☐ No

Have you had abdominal surgery: ☐ Yes ☐ No

If yes, what was the surgery for: ____

If yes, when - Date: ___________

Have you had lab work: ☐ Yes ☐ No

If yes, when - Date: ___________

If yes, where: _______________________________________

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