Advanced Radiology Services PC

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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:

_____

_____

_____

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: _____