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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: _____