Please fill out this short nutrition form and return it with your Radiation Therapy registration forms.
Please do not leave any questions blank. Thank you.

NUTRITION SCREENING

Name_____ **Date**_____

Who are your ONCOLOGY Doctor(s)?_____

What is your cancer diagnosis? _____

What Cancer treatment are you undergoing? (circle all that apply):
Surgery **Chemotherapy** **Radiation Therapy**

Nutrition Questions

I have **LOST / GAINED** (circle one) ___pounds over the past ____**WEEKS / MONTHS** (circle)

Compared to my usual, I am eating _____ (circle) in the past month.

SAME **MORE** than usual **LESS** than usual

Nutrition Support: **Tube Feedings** **TPN** **Boost, Ensure, CIB, etc…** **Soft foods**

Other ***Nutrition Concerns*** (Please explain):_____

4. NUTRITION CHALLENGES

Have you had any of the following problems prevent you from eating and maintaining a healthy weight? (Check all that apply):

€ Trouble swallowing
€ Mouth sores
€ Change in taste or smell
€ Constipation
€ Diarrhea
€ No appetite, do not feel like eating
€ Early satiety (fill up quickly)
€ Nausea/Vomiting
€ Pain with swallowing
€ Difficulty swallowing

Additional issues: _____

If you have any nutrition-related concerns or questions about your nutrition, please call us for an appointment. Nutrition consultations are complementary (no charge) for people being treated at Carol G Simon Cancer Center.

ONCOLOGY NUTRITION SERVICES (973) 971 6232