BECAUSE OF YOU MOUNT CARMEL

MOUNT CARMEL CANCER SERVICES
NUTRITION SCREENING

Name: _____ Date: _____

PAST WEIGHT HISTORY

Current Weight: _____ pounds Current Height: _____ feet _____inches

One month ago I weighed about _____pounds Six months ago I weighed about _____pounds

During the past *two weeks* my weight has:
☐ Decreased(1) ☐ Increased ☐ Not Changed

CURRENT FOOD INTAKE

Compared to my usual food intake, I would rate my food intake during the past month as:
☐ Decreased ☐ Increased ☐ Not Changed

I follow this special diet: _____
(Such as Low Sodium, Low fat, Vegan, Diabetic)

I take the following vitamins, mineral, herbal products: _____

I take the following supplement drinks:_____
(Such as Boost, Ensure, Glucerna, Instant Breakfast, Protein Shakes)

I am now taking: (Select any that apply)
☐ Regular food, same amounts
☐ Regular food but smaller amounts(1)
☐ Very little of anything(4)
☐ Very little solid food(2)
☐ Only Liquids(3)
☐ Only Tube feedings(4)

CURRENT SYMPTOMS

I have had the following problems during the past two weeks: (Select any that apply)
☐ Poor appetite(2)
☐ Taste changes(1)
☐ Constipation(1)
☐ Mouth/Throat Soreness(2)
☐ Swallowing problems(2)
☐ Nausea(1)
☐ Vomiting(2)
☐ Feel full quickly(1)
☐ Diarrhea(2)
☐ Dry Mouth(1)
☐ Smells bother me
☐ No problems