



nutritionDay
WORLDWIDE

Oncology Patient Sheet 3

Date ¹ ___ / ___ / ___

Patients number ⁵

Dear patient,
We would like you to complete this questionnaire today to optimize our nutritional care in this unit. We would like to know how you feel and how active you are.

Please check or fill in

THANK YOU FOR YOUR HELP!

patient's-Initials: ⁴ first 2 letters of your first name first 2 letters of your last name

Your usual body weight prior to becoming ill ⁵² kg I do not know

Your actual weight ⁵² kg I do not know

Was your change in weight intentionally or unintentionally? ⁵⁴
 intentionally unintentionally weight is stable

Please mark what best applies to you during the last week: ⁵⁵

	not at all	a little	quite a bit	very much
Have you had pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you need to rest?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt weak?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you feel depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Were you tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did pain interfere with your daily activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you lacked appetite?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please mark what best applies to you just now: ⁵⁵

	not at all	a little	quite a bit	very much
Do you have pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you need to rest?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel weak?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are you tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does pain interfere with your daily activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you lack appetite?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If your appetite or food intake has changed, please indicate why? ¹⁰

- nausea/vomiting constipation early satiation/loss of appetite
 inflammation in mouth diarrhea
 pain change in taste/smell other

Which of the following activities can you perform at the maximum? (choose only one option) ⁵⁶

- able to do sports able to carry out self care
 fully active able to carry out limited self care
 able to carry out light activities confined to bed or chair

What do you take without prescription from a doctor? ¹⁰

- nothing multivitamin
 herbal tea other medication
 nutritional supplements other

Which of the following activities do you perform? ¹⁰

- nothing Meditation other
 Psychotherapy Progressive muscle relaxation
 Yoga Qigong

Is it difficult to comply with your treatment? ⁹ YES NO I don't know

Did anyone help you to complete the questionnaire? ⁹ YES NO I don't know

Do you believe that including nutrition in the therapeutic approach to your cancer could provide relevant benefit to you? ⁹ YES NO I don't know