CEDARS-SINAI®
S. MARK TAPER FOUNDATION
IMAGING CENTER

GASTRIC EMPTYING QUESTIONNAIRE

PATIENT I.D.

Patient Information

Patient Name: _____ Date of scan: _____

Reason for Exam: _____

1. Are you diabetic? ❑ No ❑ Yes
2. Are you pregnant? ❑ No ❑ Yes
3. Are you nursing? ❑ No ❑ Yes
4. Current medication

	Dose	Frequency	Last Taken

5. Symptoms

	None	Very Mild	Mild	Moderate	Severe	Very Severe
Nausea *(sick to your stomach as if you are going to throw up)*	0	1	2	3	4	5
Retching *(heaving as if to vomit but nothing comes up)*	0	1	2	3	4	5
Vomiting	0	1	2	3	4	5
Stomach fullness	0	1	2	3	4	5
Not able to finish a normal-sized meal	0	1	2	3	4	5
Feeling excessively full after meals	0	1	2	3	4	5
Loss of appetite	0	1	2	3	4	5
Bloating *(feeling like you need to loosen your clothes)*	0	1	2	3	4	5
Stomach or belly visibly larger	0	1	2	3	4	5

Patient's Name *(print)*	Signature	Date	Time

Staff Name / Title	Signature	Date	Time

For Technologist Use:

Blood glucose level before scan _____ mg / dl after scan _____

Technologist: Time:

_____ _____

_____ _____

_____ _____

_____ _____

What meal was consumed for study? _____