

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Date: _____ Name: _____

Birth date: _____ Age: _____ Race: _____

REFERRING PHYSICIAN

Name: _____ City: _____ Phone Number: _____

List your recent physicians: _____

Why are we seeing you today? _____

List your recent physicians

PHYSICIAN

SPECIALTY

List recent radiology from the past 6 months (i.e., chest x-ray, mammogram, CT scan, PET scan, MRI)

DATE

TYPE OF RADIOLOGY

ORDERING PHYSICIAN

HOSPITAL/FACILITIES

1. _____
2. _____
3. _____

List lab work (past 6 months)

DATE

TYPE

ORDERING PHYSICIAN

HOSPITAL/FACILITIES

1. _____
2. _____
3. _____

List any hospitalizations, surgeries and consultations

DATE	PHYSICIAN	REASON	HOSPITAL/FACILITIES
1.			
2.			
3.			

List any biopsies or tissue removed

DATE	PHYSICIAN	REASON	HOSPITAL/FACILITIES
1.			
2.			
3.			

HEALTH HISTORY

(please check all that apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fever | <input type="checkbox"/> Hiatal Hernia/Reflux | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Genital/Urinary | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> HIV Infection |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Positive TB Test | <input type="checkbox"/> Difficulty Voiding | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Congenital | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Menstrual Difficulties | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures/-strokes | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Palpitations/Flutter | <input type="checkbox"/> Digestive Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Clots in
Legs/Lungs |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Colitis | <input type="checkbox"/> Goiter/Thyroid Disease | <input type="checkbox"/> Other |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Migraine Headaches | |

If you checked any of the above, please explain below

List any radiation treatments you have had

DATE	PHYSICIAN	TREATMENT FACILITY
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

List ANY blood transfusions you have had

DATE	HOSPITAL	ANY REACTION?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Pharmacy: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

MEDICINE AND ALLERGY

List any medications you are currently taking

Drug: _____	Dose (mg): _____	Frequency: _____
Drug: _____	Dose (mg): _____	Frequency: _____
Drug: _____	Dose (mg): _____	Frequency: _____
Drug: _____	Dose (mg): _____	Frequency: _____
Drug: _____	Dose (mg): _____	Frequency: _____
Drug: _____	Dose (mg): _____	Frequency: _____
Drug: _____	Dose (mg): _____	Frequency: _____
Drug: _____	Dose (mg): _____	Frequency: _____
Drug: _____	Dose (mg): _____	Frequency: _____
Drug: _____	Dose (mg): _____	Frequency: _____

Are you allergic to any medications, foods, IV contrast, x-ray dye or latex?

Substance: _____ Reaction: _____
Substance: _____ Reaction: _____
Substance: _____ Reaction: _____
Substance: _____ Reaction: _____

Are you diabetic? No Yes Do you have any metal implants? No Yes

Are you claustrophobic? No Yes

IMMUNIZATIONS

(check all that apply and date received if known)

- Hepatitis B _____ Influenza (annually) _____
 Pneumovax 23 Valent* _____ Prevnar Pneum. 13 Valent* _____

* Most patients will require both pneumonia vaccines (23 & 13 valent)

SOCIAL HISTORY

Smoking

- Non-smoker Light tobacco smoker (<10/day) User of moist powdered tobacco
 Current everyday smoker Pipe smoker
 Current some day smoker Chews tobacco Former smoker
 Heavy tobacco smoker (>10/day) Snuff user

Years used tobacco: _____ Packs per day: _____

- Never smoked Smoker, Current Status Unknown Unknown if ever smoked

Alcohol

- Never Former Use

Drinks per day: _____ Drinks per week: _____ Drinks per month: _____ Drinks per year: _____

Stopped alcohol use (year): _____

Substance abuse: Negative Positive Type: _____

Are you: Single Married Widowed Divorced/Separated

Are you currently working? If yes, where? _____

If you are not working is it secondary to: Retirement Disability Leave of Absence Sick Leave Other

Do you live alone? If not, who lives at home with you? _____

Are you able to care for yourself? Yes No

Are you currently living in a skilled nursing facility or a nursing home? No Yes

Are you the primary caregiver for someone unable to care for themselves? (Child, Spouse, Aging Parent, etc.)
 Yes No

What type of support system do you have in town? (Family, Friends, Church, Neighbors, Etc.) _____

If medically indicated, would you receive a blood transfusion? Yes No

Check ONLY ONE BOX to describe your activity level:

- Normal with no limitations
 Not my normal self but able to be up and about with fairly normal activities
 Not feeling up to most things but in bed or chair less than half the day
 Able to do little activity and spend most of the day in bed or chair
 Pretty much bedridden and rarely out of bed

Please check if you currently have any of the following in place:

Advance Directive: Living Will Power of Attorney DNR

FAMILY HEALTH HISTORY

Please include the following: Hypertension, Heart Attack, Congestive Heart Failure, Stroke, Emphysema, COPD, Tuberculosis, HIV, Hepatitis, Liver Disease, Anemia, Bleeding, Blood Clots in the legs or lungs, Kidney Disease, Thyroid Disease, Diabetes, Cancer (Breast, Ovarian, Colon, Lung Skin, other), Leukemia, Other

PARENTS

Name	Age	Health problems	If deceased, age & cause of death
Father:			
Mother:			

SIBLINGS

Name	Sex	Age	Health problems	If deceased, age & cause of death
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			

SPOUSE

Name	Sex	Age	Health problems	If deceased, age & cause of death
	<input type="checkbox"/> M <input type="checkbox"/> F			

CHILDREN

Name	Sex	Age	Health problems	If deceased, age & cause of death
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			

REVIEW OF SYSTEMS

(please check all that currently apply)

GENERAL

- Weight loss
- Fatigue
- Loss of appetite
- Night sweats
- Fever
- Chills

EYES

- Blurred vision
- Double vision
- Difficulty seeing
- Dry eyes

EARS/NOSE/MOUTH THROAT

- Hearing loss
- Ringing in ears
- Bleeding gums
- Nasal drainage
- Nose bleeds
- Smell changes
- Sores in mouth
- Taste changes
- Dry mouth
- Hoarseness
- Sore throat

CARDIAC

- Chest pains
- Heart palpitations
- Light headedness
- Swelling in legs
- Orthopnea
- Episodes of passing out

Date of Last EKG _____

RESPIRATORY

- Cough
- Attacks of severe SOB/Coughing at home
- Sputum production
- Hemoptysis
- Pain with breathing
- Shortness of breath

Date/Result of Last TB Test _____

Date/Result of Chest X-ray _____

BREAST

- Masses/Dimpling
- Nipple Discharge
- Nipple Inverted
- Asymmetry
- Redness/Erythema
- Scar

BREAST (CONT.)

Date/Result of Last Mammogram _____

Lump/Masses _____

Date/Location of facility _____

GASTROINTESTINAL

- Nausea
- Vomiting
- Heartburn
- Constipation
- Diarrhea
- Abdominal Pain
- Rectal Bleeding
- Bloating
- Difficulty Swallowing
- Black Stools
- Hemorrhoids
- Bowel Incontinence

Date of Last:

Rectal Exam _____

Colon Screening _____

Fecal Occult Blood Test _____

Sigmoidoscopy _____

Colonoscopy _____

GENITO-URINARY

- Lesions
- Pain/Burning with Urination
- Blood in Urine
- Urinary Incontinence

MUSCULO-SKELETAL

- Muscle Stiffness
- Joint Pain
- Joint Swelling
- Joint Stiffness
- Back Pain
- Bone Pain

SKIN

- Skin Rash
- Skin Lesions
- Acne
- Dryness
- Changes in Moles
- Infections
- Nail changes

HEMATOLOGIC/LYMPHATIC/ IMMUNOLOGIC

- Bruising
- Bleeding
- Adenopathy
- Clotting Abnormalities

NEUROLOGICAL

- Headaches
- Seizures
- Dizziness
- Loss of Balance
- Weakness Of Limbs
- Loss of Sensation
- Memory Loss
- Confusion

PSYCHIATRIC

- Depression
- Feeling Of Hopelessness
- Sadness
- Anxiety
- Restlessness
- Difficulty Sleeping
- Changes in Sex Drive

MEN ONLY

- Testicular Masses or Pain
- Penile Discharge
- Impotence
- Are both your testicles descended?
- Are you circumcised?

Date/Result of Last PSA _____

WOMEN ONLY

- Vaginal Discharge
- Itching
- Abnormal Bleeding
- Painful Periods
- Age at first menstruation? _____
- Age at menopause? _____
- Number of live births? _____
- Number of miscarriages? _____
- Have you had a hysterectomy?
- Have you had your ovaries removed?
- Have you used birth control pills?
- Have you used estrogen?
- History of Abnormal PAP Smear

Date of last Pelvic & PAP Smear _____

Physician: _____

Result: _____

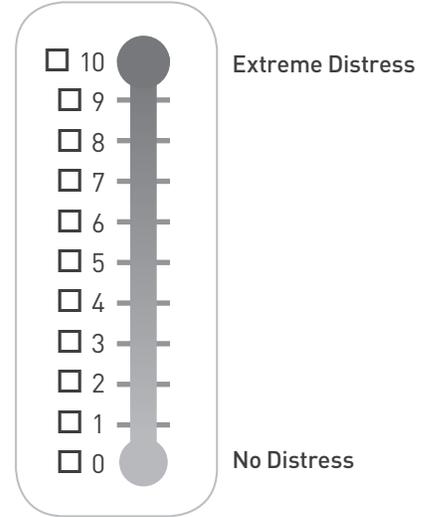
MAYO PAIN SCALE

- 0-1: No pain
 2-3: Mild pain
 4-5: Discomforting to moderate pain
 6-7: Distressing, severe pain
 8-9: Intense, very severe pain
 10: Unbearable pain
 Location: _____

HELP FOR DISTRESS

The Distress Thermometer helps your treatment team know if you need supportive services. You may be referred to supportive services at your cancer center or in your community. Supportive services can include help from support groups, chaplains, social workers, counselors and many other experts.

Please check the number 0-10 that best describes how much distress you have been experiencing in the past week, including today



Yes	No	Emotional Problems
		Depression
		Anxiety
		Difficulty coping
		Sadness
		Restlessness
		Difficulty sleeping
		Libido changes
		Spiritual/religious concerns

Yes	No	Family Problems
		Dealing with children
		Dealing with partner
		Ability to have children
		Family health issues

← Please indicate if any of the following has been a problem for you in the past week including today. **Be sure to check "yes" or "no" for each.**

Yes	No	Practical Problems
		Child care
		Housing
		Insurance/financial
		Transportation
		Work/School
		Treatment decisions