



Community Cancer Center

Phone: (541) 673-2267 or Toll free (866) 836-4448

Appointment Date & Time:	Place Name Sticker Here
Referring Physician:	Family Physician:

PATIENT HISTORY QUESTIONNAIRE

Initial Re-Evaluation

ESCORT INFORMATION

Marital Status: Single Married Separated Divorced Widowed Significant Other

Spouse or Significant Other's name: _____

Who will accompany you on your first visit? _____

Do you wish to have your escort included in your initial meeting with the physician? Yes No

If yes, relationship and name: _____

May we discuss your medical diagnosis and treatment with your family? Yes No

Exclusions? Yes No _____

WORK HISTORY

Occupation: _____

Are you still working? Yes No Hours: _____

Has your illness forced you to stop working? Yes No Date: _____

Do you anticipate being off work? Yes No Date: _____

Has your illness forced significant other to stop working? Yes No Date: _____

Has your illness forced significant other to change hours? Yes No Date: _____

PAST SURGERIES OR HOSPITALIZATIONS List any surgeries and year performed. None

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

OTHER MEDICAL ILLNESSES OR CONDITIONS, CURRENT OR PAST (Heart disease, diabetes, etc.)

List any and year occurred. None

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

MEDICATIONS List all current medications and doses. Please include all over-the-counter, herbal and non-prescription medications. None

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Community Cancer Center

Place Name
Sticker Here

HISTORY OF TOBACCO, ALCOHOL, and EXPOSURES

Tobacco

Ever use tobacco? Yes No
 Currently use tobacco? Yes No

How many packs per day? _____
 What age started? _____
 What age stopped? _____

If yes, check type(s):

Cigarettes Chew
 Pipe Cigars
 Snuff

To be completed by Nurse:

Total Pack Years: _____

Alcohol

Ever use alcohol? Yes No
 Currently use alcohol? Yes No

If yes, list type/amount? _____
 What age started? _____
 What age stopped? _____

CURRENT PROGRAMS

Are you participating in any programs? Yes No

If yes, Smoke Cessation program AA Other _____

Were you exposed to carcinogenic substances, asbestos? Yes No List: _____

FAMILY HISTORY OF CANCER

Immediate	Type of Cancer	Maternal	Type of Cancer	Paternal	Type of Cancer
Mother	<input type="checkbox"/> Yes	Grandmother	<input type="checkbox"/> Yes	Grandmother	<input type="checkbox"/> Yes
Father	<input type="checkbox"/> Yes	Grandfather	<input type="checkbox"/> Yes	Grandfather	<input type="checkbox"/> Yes
Sister	<input type="checkbox"/> Yes	Aunt	<input type="checkbox"/> Yes	Aunt	<input type="checkbox"/> Yes
Brother	<input type="checkbox"/> Yes	Uncle	<input type="checkbox"/> Yes	Uncle	<input type="checkbox"/> Yes
Children	<input type="checkbox"/> Yes				

FAMILY HISTORY

Please check the appropriate box if there is a history of the following disease(s) in your immediate family.

Heart Disease High Blood Pressure Stroke Diabetes

List other hereditary diseases: _____

Mother Alive Deceased Cause: _____ Age: _____

Father Alive Deceased Cause: _____ Age: _____

Children # _____ Alive # _____ Well # _____ Natural # _____ Adopted Able to Assist

GENERAL HISTORY

Before my current illness, I would describe my overall health as:

Excellent Good Fair Poor

At the present time I feel:

Excellent Good Fair Poor

PAST CANCER HISTORY

Have you ever had any of the following?

Prior Cancers Prior Radiation Prior Chemotherapy None Apply

Are you taking hormonal therapy (i.e., Tamoxifen)? No Yes If yes, what? _____

What other doctors have you seen for your current diagnosis? _____

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REVIEW OF SYSTEMS: Please ✓ any of the items that apply to you or that you may be experiencing.

CHIEF COMPLAINT: Please explain in your own words, the reason you are here today.

GENERAL HISTORY

- Normal Weight: _____
 Recent Weight Loss
 Amount: _____
 Recent Weight Gain
 Amount: _____
 Loss of appetite
 Fatigue
 Weakness
 Fevers
 Chills
 Night sweats
 Sleep problems

EYES

- Glasses
 Contact Lenses
 Glaucoma
 Cataracts
 Double vision
 Change in vision
 Other vision problems

EARS/NOSE/THROAT

- Loss of hearing
 Hearing aid
 Ringing in ears
 Other ear problems
 Dentures
 Dental problems
 Frequent sore throats
 Hoarseness
 Difficulty swallowing
 Dry mouth
 Loss of taste
 Neck stiffness
 Neck pain or swelling

CARDIOVASCULAR

- Pacemaker
 Chest pain
 Irregular heartbeat
 Palpitations
 Hypertension
 Sleep sitting or propped up
 Short breath when lying down
 Fainting spells
 Leg pain while walking
 Swelling in feet
 Varicose veins
 Oxygen use at home

RESPIRATORY

- Shortness of breath
 Difficulty breathing
 Coughing
 Dry cough
 Coughing up sputum
 Coughing up blood

GASTROINTESTINAL

- Heartburn
 Nausea/upset stomach
 Abdominal pain
 Vomiting
 Jaundice
 Change in bowel habits
 How long? _____
 Constipation
 Diarrhea
 Blood in stool
 Hemorrhoids/fissures

GENITOURINARY

- Difficulty urinating
 Frequent urination
 Painful urination
 Up at night to pass urine
 Blood in urine
 Color change of urine

WOMEN ONLY

- Date of last menstrual period: _____
 Menopause
 Hot flashes
 Hormone therapy
 Currently sexually active
 _____ # of pregnancies

MEN ONLY

- Impotence
 Difficulty with erections
 Penile discharge
 Testicular mass
 Testicular pain

MUSCULOSKELETAL

- Leg cramps
 Painful muscles
 Painful joints
 Artificial joints
 Physical disabilities
 Gout

SKIN & BREAST

- Itching
 Blotchy
 Rash
 Scaling
 Sores
 Color changes
 Pain in breast
 Growths
 Lump or mass in breast or armpit
 Discharge or bleeding from nipple
 Change in nipple
 Nipple inversion
 Change in size, shape or contour of breast

NEUROLOGICAL

- Headaches
 Tremors
 Memory loss
 Difficulty finding words
 Difficulty writing
 Difficulty thinking clearly
 Numbness or tingling
 Dizziness
 Loss of consciousness
 Seizures
 Coordination
 Unsteady gait

PSYCHIATRIC

- Nervousness
 Anxiety
 Depression
 Change in personality
 Relationship problems

ENDOCRINE

- Excessive thirst
 Excessive urination
 Thyroid problems

HEMATOLOGIC & LYMPHATIC

- Swollen lymph glands
 Excessive bruising
 Excessive bleeding

ALLERGY & IMMUNOLOGY

- Medications
 Latex allergies
 Food or non-medication allergies
 Tape allergies
 Hay Fever
 None

ALLERGIES: _____

PAIN

Do you currently have any pain? Yes No If yes, where? _____

Please rate your current pain on a scale of 1-10. 1 being the best, or no pain. 10 being the worst, or intolerable.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Does medication relieve your pain? Yes No When does your pain usually occur? _____

Patient Signature _____ Date _____

Community Cancer Center

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THIS SECTION TO BE INTERVIEWED BY NURSE

Physical Examination:

Vital Signs: BP _____ P _____ R _____ T _____ HT _____ WT _____
Pulse oximetry with O2 _____ On RA _____

COGNITIVE ASSESSEMENT

- Alert/Oriented
- Confused
- Short-Term Memory Deficits
- Long Term Memory Deficit
- Impaired Decision Making
- Cognitive deficits will affect patient's care plan

ENERGY Independent

- Maintain ADLs
- Weakness
- # hrs sleep per night _____
- # hrs sleep per day _____
- Does own cooking

MOBILITY

- No difficulty
- Weakness
- Unsteady
- Falls
- Paralysis _____

USES None

- Cane Bathing
- Crutches
- Walker
- Wheelchair

NEEDS ASSISTANCE WITH:

- 2-person assist
- Transfers In assisted living
- Feeding Stand-by assist
- Dressing
- Ambulation

PAIN None

Location _____ Severity (1-10) _____

Medications: OTC NSAIDS Opiates Adjuvant
Are medications effective? Yes No Duration of relief? _____
Prescription coverage? Yes No

UPDATED ALLERGIES/MEDICATIONS ON FLOWSHEET REVIEWED SOCIO-ECONOMIC FROM INITIAL HISTORY QUESTIONNAIRE

Comments: _____

NUTRITIONAL SCREEN

	YES	NO
Without trying to, have you lost or gained 10 pounds in the last 6 months?		
Do you have an illness or condition that made you change the kind and/or amount of food you eat?		
Do you eat fewer than 2 meals per day?		
Do you eat less than 3 fruits or vegetables, or 3 milk products per day?		
Do you have 3 or more drinks of beer, liquor or wine almost every day?		
Do you have tooth, mouth or swallowing problems that make it hard for you to eat?		
Do you have enough money to buy the food you need?		
Do you eat alone most of the time?		
Do you take 3 or more different prescribed or over the counter drugs a day?		
Are you physically unable to shop, cook and/or feed yourself and have no one available to help?		

Total the nutritional score.

- Patient at moderate nutritional risk (3-5 points)
- Patient at high nutritional risk (6 or more points)

Other modifying factors:

Field Size _____ Treatment Site _____ Postop _____

Chemo? Prior Concomitant

Action taken:

- Patient to see RN for further dietary instruction.
- Nutritional Counseling is unrelated to cancer treatment.
- Other _____
- MMC Fax 677-6569
- MRCC Fax 677-2126
- VAMC Fax 440-1251

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Functional Assessment/Karnofsky _____

Pages 1 – 4 Reviewed by Nurse _____

Date _____

Pages 1 – 4 Reviewed by Physician _____

Date _____

THIS SECTION TO BE COMPLETED BY PATIENT ADVOCATE

CURRENT LIVING ARRANGEMENTS

- Independent Live Alone Lives with other(s)
 Assisted Living _____ Nursing Home _____

Number living in house _____ Relationship(s) _____

What floor does patient live on? _____ Does the patient feel their living environment is safe? Yes No

Has the diagnosis of cancer forced a change in the patient's usual living situation? Yes No

Describe _____

COPING AND SUPPORT RESOURCES

PRINCIPAL SUPPORT PERSON

Name: _____

Health Issues of Principal Support Person That May Affect Care None

Describe: _____

EXTENDED FAMILY/FRIENDS SUPPORT (who would be available to drive, help around home if necessary)

OTHER SUPPORT RESOURCES (Church, club affiliations, etc.)

- Senior Services Meals on Wheels Home Health or Hospice services
 Disability Service Senior Companion Other: _____
Caseworker _____

Is support system adequate to fit patient's needs? Yes No

Describe _____

FUNCTIONAL STATUS

Does patient exercise regularly? Yes No

Type of exercise/frequency? _____

Does patient drive? Yes No _____

Does patient have a vehicle available for transport? Yes No _____

If patient is continuing to work, what are work hours? _____

FINANCIAL STATUS

Insurance _____ No insurance Referred for CCC Financial Counseling

Does patient need financial assistance for medications? Yes No

If yes, applying for assistance through Pharmaceutical company CCC Pharmacy Assistance Program

Nursing Comments: _____

Completed by: _____ Date: _____