



# 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
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Does medication relieve your pain?  Yes  No When does your pain usually occur? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_