Community Cancer Center

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

Appointment Date & Time:	Place Name Sticker Here
Referring Physician:	Primary Care Provider:

PATIENT HISTORY QUESTIONNAIRE ❑ Initial ❑ Re-Evaluation

Race: ❒ American Indian or Alaska Native ❒ Asian ❒ African American ❒ Pacific Islander ❒ Caucasian ❒ Decline to Provide

Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Decline to Provide **Preferred Language:** _____

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? Please provide name and relationship.

_____

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

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

Exclusions? ❑ Yes ❑ No _____

WORK HISTORY

Occupation: _____

Currently employed? ❑ 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: _____

PAST SURGERIES OR HOSPITALIZATIONS

List any and year performed. ❑ None

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

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

List any and year occurred. ❒ None

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

Do you have a history of MRSA? ❑ Yes ❑ No Date: _____

Do you have any implanted devices (pacemaker, nerve stimulator)? ❑ Yes ❑ No List: _____

Have you had your flu vaccine this year? ❑ Yes ❑ No Date: _____

MEDICATIONS

❒ None Preferred Pharmacy: _____

List all current medications and doses including all over-the-counter, herbs, vitamins and non-prescription medications.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

ALLERGIES: _____

Do you have a POLST or Advanced Directive? ❑ Yes ❑ No

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Sticker Here

FAMILY HISTORY OF CANCER

Immediate		Type of Cancer	Maternal		Type of Cancer	Paternal		Type of Cancer
Mother	☐Yes		Grandmother	☐Yes		Grandmother	☐Yes	
Father	☐Yes		Grandfather	☐Yes		Grandfather	☐Yes	
Sister	☐Yes		Aunt	☐Yes		Aunt	☐Yes	
Brother	☐Yes		Uncle	☐Yes		Uncle	☐Yes	
Children	☐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

HISTORY OF TOBACCO, ALCOHOL, and EXPOSURES

Tobacco

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

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

CURRENT PROGRAMS

Are you participating in any chemical dependency programs? ❒ Yes ❒ No
If yes, ❒ Smoke Cessation program ❒ AA ❒ Other _____

Were you exposed to carcinogenic substances, asbestos? ❑ Yes ❑ No List: _____
Do you have a history of illegal drug use? ❑ Yes ❑ No List: _____

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, Lupron)? ❒ 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
❑ Constipation
❑ Diarrhea
❑ Blood in stool
❑ Hemorrhoids/fissures
❑ Colonoscopy Date of Last: _____

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

WOMEN ONLY
Age of Menarche ___ Age of Menopause ___
Date of last menstrual period: _____
Date of last pelvic exam: _____
Date of last pap: _____
❑ Abnormal vaginal bleeding
❑ Hot flashes
❑ Hormone therapy
❑ Currently sexually active
Is there a chance you may be pregnant?
❑ Yes ❑ No
____# of pregnancies ____# living

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
❑ Mammogram Date of Last: _____

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

PAIN

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

Please circle your current pain level on a scale of 0-10 (0 being no pain and 10 being the worst pain, or intolerable).

0	1	2	3	4	5	6	7	8	9	10

Do you take medication for this pain? ❒ Yes ❒ No List: _____
Is this medication effective for your pain? ❒ Yes ❒ No

Overall Health

Please mark on the scale below to demonstrate how you feel your overall health is today.

0 = Worst Imaginable Health State 100 = Best Imaginable Health State

0	10	20	30	40	50	60	70	80	90	100

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Sticker Here

MOBILITY
❒ Independent
❒ Needs Assistance
❒ Transfers ❒ Cane
❒ Wheelchair ❒ Crutches
❒ Walker
❒ Bedbound
History of falls? ❒ Yes ❒ No

DAILY ACTIVITY
❒ Independent
❒ Needs Assistance
❒ Bathing
❒ Dressing
❒ Feeding
❒ Unable to perform

ANXIETY/DEPRESSION
❒ I am not anxious/depressed
❒ I am moderately anxious/depressed
❒ I am extremely anxious/depressed
❒ # hrs sleep per night _____
❒ # hrs sleep per day _____

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

NUTRITIONAL SCREEN

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

CURRENT LIVING ARRANGEMENTS
❒ Live Alone ❒ Live 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_____

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 ❒ Senior Companion
❒ Disability Service (Caseworker _____) ❒ Other: _____
Is your support system adequate to fit your needs? ❒ Yes ❒ No
Describe _____

Patient Signature _____ Date _____