Community Cancer Center

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

Appointment Date & Time:	Patient Name:
Referring Physician:	Primary Care Provider:

PATIENT HISTORY QUESTIONNAIRE

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 (Previous occupation, if retired): _____

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: _____

MEDICATIONS ❒ None

Preferred Pharmacy: _____

List all current medications and doses including all over the counter 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

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

Do your currently use tobacco or have history or using tobacco? ❒ Yes ❒ No
How many packs have you or are you currently smoking per day? _____
What year started? _____What year stopped? _____

If yes, check type(s):

❒ Cigarettes ❒ Chew ❒ Snuff
❒ Pipe ❒ Cigars

To be completed by Nurse:
Total Pack Years: _____

Alcohol/Drug Use

Do you currently use alcohol or have a history of using alcohol? ❒ Yes ❒ No
If yes, list type/amount? _____
What year started? _____What year stopped? _____
Are you currently using illicit drugs and/or marijuana? ❑ Yes ❑ No List: _____
Do you have a history of illicit drug and/or marijuana use? ❑ Yes ❑ No List: _____

Carcinogenic Substances

Exposure to carcinogenic substances? ❒ Yes ❒ No
If yes, check type(s): ❒ Asbestos ❒ Second-hand smoke ❒ Other _____

CURRENT PROGRAMS

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

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
Are you taking hormonal therapy (i.e., Tamoxifen, Lupron)? ❒ No ❒ Yes If yes, what? _____
Are you currently receiving chemotherapy? ❒ No ❒ Yes If yes, what? _____
What other doctors have you seen for your current diagnosis? _____

Community Cancer Center

Patient Name:_____

CHIEF COMPLAINT: _____

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: _____ Menopause: _____
Date of last menstrual period: _____
Date of last pelvic exam: _____
Date of last PAP: _____
Oral Contraceptives: ❑ Current ❑ Past
- ❑ 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

PAIN
Do you currently have any pain? ❒ Yes ❒ No If yes, where? _____ Current Pain Level: _____
Do you take medication for this pain? ❒ Yes ❒ No List: _____ Medication effective? ❒ Yes ❒ No

VACCINES
flu vaccine? ❒ Yes ❒ No Date: _____ pneumonia vaccine? ❒ Yes ❒ No Date: _____
shingles vaccine? ❒ Yes ❒ No Date: _____ COVID-19 vaccine? ❒ Yes ❒ No Date: _____

Community Cancer Center

Patient Name:_____

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

Have you lost weigh involuntarily in the last 3 months? ❒ Yes ❒ No ❒ Unsure
If yes, how much weight (lbs.) have you lost? ❒ 2.2– 12.4 ❒ 12.5 – 22.7 ❒ 22.8 – 33 ❒ >33 lbs ❒ Unsure
Have you been eating poorly in the last week because of decreased appetite? ❒ Yes ❒ No
Do you eat as least 2 meals per day? ❒ Yes ❒ No
Do you have enough money to buy food? ❒ Yes ❒ No
If no, do you receive SNAP benefits? ❒ Yes ❒ No
Do you eat alone most of the time? ❒ 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 _____