

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Date: _____ Name: _____

Birth date: _____ Age: _____ Race: _____

REFERRING PHYSICIAN

Name: _____ City: _____ Phone number: _____

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/FACILITY

1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

List lab work (past 6 months)

DATE

TYPE

ORDERING PHYSICIAN

HOSPITAL/FACILITY

1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

SURGERIES OR HOSPITALIZATIONS

DATE	PHYSICIAN	REASON	HOSPITAL/FACILITY
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

List any biopsies or tissue removed

DATE	PHYSICIAN	REASON	HOSPITAL/FACILITY
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

PERSONAL 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"/> High Cholesterol	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Menstrual Difficulties	<input type="checkbox"/> Anemia
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures/Stroke	<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. _____	_____	_____

Preferred pharmacy: _____ Phone: _____

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

24-Hour pharmacy: _____ Phone: _____

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

MEDICATIONS

List all medications you are currently taking (including over the counter and supplements)

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: _____

ALLERGIES

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* _____ ☐ PrevnarPneum. 13 Valent* _____

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

☐ HPV #1 _____ ☐ Shingles _____

☐ HPV #2 _____

☐ HPV #3 _____

ADVANCE CARE PLANNING

Please check if you currently have any of the following in place and please bring a copy to the office :

LIVING WILL

- ☐ Yes, I have provided a copy
- ☐ Yes, I will bring a copy at my next visit
- ☐ No, but I would like assistance in completing one
- ☐ No, I am not interested at this time

DNR (DO NOT RESUSCITATE)

- ☐ Yes, I have provided a copy
- ☐ Yes, I will bring a copy at my next visit
- ☐ No, but I would like assistance in completing one
- ☐ No, I am not interested at this time

POWER OF ATTORNEY

- ☐ No
- ☐ Yes, I have provided a copy
- ☐ Yes, I will bring a copy at my next visit

SOCIAL HISTORY

Smoking

- | | | |
|---|--|---|
| <input type="checkbox"/> Never smoked | <input type="checkbox"/> Former smoker
Date Stopped _____ | <input type="checkbox"/> Chews tobacco |
| <input type="checkbox"/> Current every day smoker | <input type="checkbox"/> Light tobacco smoker (<10/day) | <input type="checkbox"/> Snuff user |
| <input type="checkbox"/> Current some day smoker | <input type="checkbox"/> Pipe smoker | <input type="checkbox"/> User of moist powdered tobacco |
| <input type="checkbox"/> Heavy tobacco smoker (>10/day) | | <input type="checkbox"/> Vaping |

Years of tobacco use: _____ Packs per day: _____

Alcohol Use

- ☐ Never ☐ Current Use ☐ Former Use Stopped alcohol use (year): _____
- Drinks per day: _____ Drinks per week: _____ Drinks per month: _____ Drinks per year: _____

Recreational Substance use: ☐ Yes ☐ No Type: _____

Medical Marijuana use: ☐ Yes ☐ No If yes, do you have a license? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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:

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

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 or gain #lbs _____
- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Fever—temp max _____ when _____
- ☐ Chills

EYES

- ☐ Blurred 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 headaches
- ☐ Swelling in legs
- ☐ Episodes of passing out

Date of last EKG _____

RESPIRATORY

- ☐ Cough
- ☐ Sputum production
- ☐ Blood in sputum
- ☐ 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—last BM _____
- ☐ Diarrhea—# stools in 24 hrs _____
- ☐ Abdominal pain
- ☐ Rectal bleeding
- ☐ Bloating
- ☐ Difficulty swallowing solids or liquids
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Bowel incontinence

Date of rectal exam _____

Date of last colon screening _____

Date of fecal occult blood test _____

Date of sigmoidoscopy _____

Date of colonoscopy _____

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

NEUROLOGICAL

- ☐ Headaches
- ☐ Seizures
- ☐ Double vision
- ☐ Dizziness
- ☐ Loss of balance

NEUROLOGICAL (CONT.)

- ☐ Weakness of limbs
- ☐ Numbness or tingling:
Location _____
- ☐ Memory loss
- ☐ Confusion

HEMATOLOGIC/LYMPHATIC/ IMMUNOLOGIC

- ☐ Bruising
- ☐ Bleeding
- ☐ Swollen lymph nodes
- ☐ Clotting abnormalities

MEN ONLY

- ☐ Lesions
- ☐ Pain/burning with urination
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ Testicular masses or pain
- ☐ Penile discharge
- ☐ Impotence
- ☐ Are both your testicles descended?
- ☐ Are you circumcised?

Date/result of last PSA _____

WOMEN ONLY

- ☐ Lesions
- ☐ Pain/burning with urination
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ 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

☐ 10 Extreme Distress
☐ 9
☐ 8
☐ 7
☐ 6
☐ 5
☐ 4
☐ 3
☐ 2
☐ 1
☐ 0 No Distress

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	Emotional Problems
		Depression
		Anxiety
		Difficulty coping
		Sadness
		Restlessness
		Difficulty sleeping
		Sex drive changes
		Spiritual/religious concerns

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

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