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

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? ____

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. ____________________________ _____________

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

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

MEDICATIONS ❐ None

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

1. ___________________________________ 6. ___________________________________

2. ___________________________________ 7. ___________________________________

3. ___________________________________ 8. ___________________________________

4. ___________________________________ 9. ___________________________________

5. ___________________________________ 10. ___________________________________

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 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 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: ________________________

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

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

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

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?________________________

Community Cancer Center

Place Name
Sticker Here

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

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: ________
- ❑ 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

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 circle your current pain rating 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

Do you take medication for this pain? ❑ Yes ❑ No List:_________________________________

Is this medication effective for your pain? ❑ Yes ❑ No

Community Cancer Center

Place Name
Sticker Here

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
- ❐ Crutches
- ❐ Walker
- ❐ Wheelchair

NEEDS ASSISTANCE WITH:
- ❐ Bathing
- ❐ Dressing
- ❐ Ambulation
- ❐ Feeding
- ❐ Transfers
- ❐ Stand-by assist
- ❐ 2-person assist

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 drugs a 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

❐ 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____

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 ____

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 (refer to CCC Financial Counseling)

Patient Signature ____ Date ____________________________