

The following information is necessary to assist the healthcare team in providing you with comprehensive and individualized care.

PATIENT DEMOGRAPHICS	
Name: _____	Date of First Visit: _____
What do you prefer to be called? _____	Date of Birth: _____
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Single	
Race: <input type="checkbox"/> White (Caucasian) <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American/Native Alaskan	
<input type="checkbox"/> Hispanic (country of origin) _____ <input type="checkbox"/> Other _____	
Where were you born? _____ <div style="display: flex; justify-content: space-between; font-size: small;"> (City) (County) (State) </div>	
Born in foreign country: _____ Moved to US (year): _____	
Do you speak/read/understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No	
ADVANCE DIRECTIVES	
Do you have an advance directive (living will or medical-durable power of attorney)? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, please bring a copy with you. If not, would you like to speak with someone about an advance directive? <input type="checkbox"/> No <input type="checkbox"/> Yes	
PHYSICIAN INFORMATION	
Please list the complete name, address, and phone number of referring physicians whom you would like to have informed of your diagnosis, treatment, and care.	
Name: _____ <input type="checkbox"/> Check if this is your primary care physician	Specialty: _____
Address: _____ Phone: () _____	
Name: _____ <input type="checkbox"/> Check if this is your primary care physician	Specialty: _____
Address: _____ Phone: () _____	
Name: _____ <input type="checkbox"/> Check if this is your primary care physician	Specialty: _____
Address: _____ Phone: () _____	
HEALTH HISTORY	
Please list all major diseases, illnesses or conditions for which you have been treated or hospitalized.	
Disease/Illness/Condition	Date of Diagnosis
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

HEALTH HISTORY (cont.)

Have you ever been to the the following? (Check all that apply)

- Agent Orange Asbestos Benzine Coal Dust
 Pesticides Radiation Heavy Metals

Have you been exposed to, or diagnosed with any of the following? (Check all that apply)

- Hepatitis Shingles Tuberculosis (TB)
 Chicken Pox (exposed within the last 8 weeks) Other: _____

Do you smoke, or have you in the past? No Yes Cigarettes Pipe Cigars

Amount per day: _____ Number of years: _____ Quit date: _____

Do you drink alcohol, or have you in the past? No Yes Beer Wine Hard Alcohol

Amount per day: _____ Number of years: _____ Quit date: _____

Do you use recreational drugs, or have you in the past? No Yes Type: _____

Amount per day: _____ Number of years: _____ Quit date: _____

CANCER HISTORY

Type of cancer (body part with cancer)	Year diagnosed	Treatment	Hospital/doctor's office where you received treatment
		<input type="checkbox"/> Surgery <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Biotherapy	Name: City/State: Phone #:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Biotherapy	Name: City/State: Phone #:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Biotherapy	Name: City/State: Phone #:

Are you using any alternative treatments? No Yes

If yes, please check all that apply: Herbal supplement Nutritional aids Vitamins
 Relaxation Therapeutic touch Other: _____

Please list any immediate family members who have had cancer (Mother, Father, Sister, Brother)

Relative	Type of Cancer	Age when diagnosed	Still Living?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

**Please list any *other* relatives who have had cancer (Grandparents, Aunts, Uncles, Cousins).
Do not include people who are related to you only by marriage.**

Relative	Related to you through:	Type of Cancer
	<input type="checkbox"/> Mother <input type="checkbox"/> Father	
	<input type="checkbox"/> Mother <input type="checkbox"/> Father	
	<input type="checkbox"/> Mother <input type="checkbox"/> Father	

SOCIAL DEMOGRAPHICS/FAMILY

With whom do you live? _____

Do you have children? No Yes Ages: _____

Are you responsible for the care of someone else? No Yes Whom? _____

If you are in need of help at home, who will be available to assist you? _____

What is your highest level of education? Grade school High school College Post-graduate

What is the easiest way for you to learn new things? Written Video
 Demonstration Oral Instruction

Are you employed? Yes Self-employed
 No Date you stopped working _____ Retired Disabled

What is/was your occupation? _____

Are you having employment problems? No Yes (please explain): _____

Is spirituality/religion important in your life? No Yes

Are there any religious, traditional, ethnic, or cultural practices that you would like to be part of your care?

No Yes (please explain): _____

COPING

Since you became ill, have you felt any of the following? (check all that apply)

- Nervous, or more nervous than normal Overwhelmed by emotions Angry
 Depressed, or more depressed than normal Difficulty with concentration Sad
 Other: _____

Do you have a lot of stress in your life? No Yes

Have you noticed a change in your normal sleeping pattern?

(sleeping more than usual, or difficulty in sleeping)

If yes, explain: _____ No Yes

Have you ever taken medications for emotional problems? No Yes

Have you ever been hospitalized for emotional problems? No Yes

Are you concerned about how your illness will affect your family? No Yes

Are you concerned about any particular member of your family who may have experienced difficult emotional reactions as a result of your illness? No Yes

Since your diagnosis, have you noticed a change in your relationship with your partner? No Yes

Do you have concerns about sexual/reproductive issues? No Yes

Have you experienced changes in your sexual desire or function that are troubling you? No Yes

Have you ever been physically, emotionally, verbally, or sexually abused? No Yes
If you have been abused, have you sought help? No Yes

Are you concerned about how your illness will affect your financial resources? No Yes

Are you comfortable whether or not your insurance coverage and personal resources can meet the costs of your care? No Yes

Are you having problems with the cost of your medications? No Yes

What concerns you most about your illness? _____

SKIN

Do you have any of the following? (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Changes in moles | <input type="checkbox"/> Tendency to bruise easily | <input type="checkbox"/> Mouth sores or mouth ulcers |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Changes in skin color | <input type="checkbox"/> New sores or open wounds |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Dry or itchy skin | <input type="checkbox"/> Other: _____ |

NUTRITION

Have you lost 10 pounds or more in the last 1-3 months without trying? No Yes

Have you been eating fewer than 2 meals per day, or have you been skipping regular meals? No Yes

Do you become full easily and eat less than you used to? No Yes

Are you physically able to shop, cook, and/or eat? No Yes

Do you have enough money to buy the food you need? No Yes

Please check any of the following symptoms that are preventing you from eating:

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pain | <input type="checkbox"/> Mouth or throat problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Change in taste | <input type="checkbox"/> Other: _____ |

ACTIVITY

Are you having difficulty walking? No Yes

Have you fallen in the last month? No Yes

Have you noticed a difference in your strength/dexterity that interferes with your daily activity? No Yes

Do you need help with any of the following:

- | | | | | |
|----------------------------------|------------------------------------|---|--|---|
| <input type="checkbox"/> Eating | <input type="checkbox"/> Bathing | <input type="checkbox"/> Dressing | <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Meal Preparation |
| <input type="checkbox"/> Writing | <input type="checkbox"/> Toileting | <input type="checkbox"/> Transportation | <input type="checkbox"/> Taking Medication | |

HOME CARE INFORMATION

If you have home care services or home care infusion services, please list the names and phone numbers of these agencies:

Name: _____ Phone: _____

Name: _____ Phone: _____

ACCESS DEVICE

Do you have a catheter in your arm or chest for drawing blood or for receiving medication? No Yes

If yes, please complete the following:

What type of catheter do you have? _____

When was it inserted? _____

Who placed the catheter? _____

At what facility was the catheter inserted? _____

What is the catheter used for? _____

Have you had any problems or difficulties with your catheter? No Yes

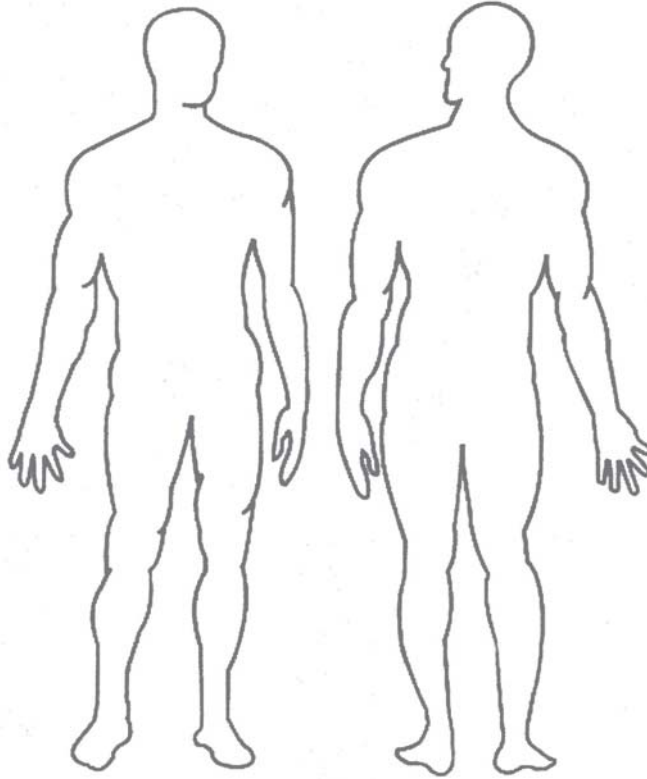
If yes, please explain: _____

COMFORT

Have you had pain today? No Yes

If yes, please describe: _____

On the diagram, mark the areas where you feel pain.



Please rate your pain by circling the number that best describes your pain at its worst in the past 24 hours.

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

During the past 24 hours, has the pain interfered with your:

General activity	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Sleep/Rest/Relaxation	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mood	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Walking ability	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Enjoyment of life	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Normal work	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Relations with other people	<input type="checkbox"/> No	<input type="checkbox"/> Yes			

What treatment or medications are you receiving for your pain? _____

ADDITIONAL INFORMATION

Please list any additional information that you think would assist us in providing you the best possible care:

Height: _____ Weight: _____ Recent weight change? No Yes

Head, Eyes, Ears, Nose, Throat & Neck

Double Vision No Yes
Headaches No Yes
Seizures No Yes
Dizziness No Yes
Hard of hearing No Yes
Thyroid problems No Yes
Other (please explain): _____

Respiratory:

Spitting up blood No Yes
Asthma/Wheezing No Yes
Difficulty Breathing No Yes
Pleurisy/pneumonia No Yes
Other (please explain): _____

Cardiovascular:

Chest pain/angina No Yes
Shortness of breath No Yes
Difficulty walking (2 blocks) No Yes
Heart problems/attacks No Yes
High blood pressure No Yes
Heart murmur No Yes
Swelling of hands, feet No Yes
Other (please explain): _____

Hematologic:

Bleeding tendencies No Yes
Anemia No Yes
Blood disease No Yes
Other (please explain): _____

Gastrointestinal

Peptic Ulcer No Yes
Vomiting blood/food No Yes
Gallbladder disease No Yes
Liver problems No Yes
Hepatitis No Yes
Painful bowel movements No Yes
Bleeding w/bowel movements No Yes
Black stools No Yes
Hemorrhoids No Yes
Recent change in bowel habits No Yes
Frequent diarrhea No Yes
Heartburn No Yes
Cramping/pain in abdomen No Yes
Food sticking in throat No Yes
Other (please explain): _____

Neuro-Psychiatric:

Loss of consciousness No Yes
Convulsions No Yes
Fainting spells No Yes
Prior psychiatric history No Yes
Other (please explain): _____

Genitourinary:

Frequent urination No Yes
Burning/painful urination No Yes
Blood in urine No Yes
Kidney problems No Yes
Other (please explain): _____

WOMEN ONLY:

Age your periods started: _____
Are you still having regular menstrual periods? No Yes
If no, at what age did your periods stop? _____
If yes, date of your last period: _____
Number of days period lasts: _____
Do you have pain with your periods? No Yes
Number of pregnancies: _____
Number of miscarriages: _____
Number of children: _____
Age at time of your first delivery: _____
Did you nurse your child(ren)? No Yes
Do you practice monthly breast self-examinations? No Yes

Date of last PAP smear: _____
Results: _____
Ever been treated for abnormal PAP smear? No Yes
Explain: _____
Ever had a pelvic infection? No Yes
Do you currently use birth control? No Yes
What type: _____
What other birth control have you used in the past?

Have you had a hysterectomy? No Yes
Are you currently on hormone therapy? No Yes

Signature of Patient **X** _____ Date: _____

or
Signature of person completing this form **X** _____ Date: _____

Relationship to patient: _____