

Fill before your first visit



Name

Date:

Tell us about your PRESENT ILLNESS:

Your MEDICAL HISTORY: What other disease or conditions do you have now or had in the past?

Please describe below and provide approximate dates of diagnosis, details of treatment and the name and contact information of a doctor who is taking care of you

- Other cancers:

- Cardiac disorders: Heart attack, angina, cardiac stents, high blood pressure, valve problems, heart murmurs, other heart diseases

- Vascular disorders: blood clots, emboli, strokes, carotid stenosis, transient ischemic attacks

- Lung disorders: asthma, chronic bronchitis, emphysema, other lung diseases

- Gastro-Intestinal disorders: esophagitis, gastritis, peptic ulcer, colitis, celiac disease, hepatitis, liver cirrhosis, hepatitis C or B positivity, pancreatitis, colitis, other gastrointestinal diseases

- Endocrine disorders: diabetes, thyroid diseases, other endocrine diseases

- Rheumatologic disorders: arthritis, spinal stenosis, osteoporosis, lupus, vasculitis, other rheumatologic disorders

- Urologic disorders: any urologic disorders

- Neurologic disorders: neuropathy, seizure disorder, Parkinson's disease, other neurologic diseases (please describe)

- Please list everything that comes to mind which we have not mentioned above.

Cancer screening history:

- Last mammogram
- Last colonoscopy
- Last PSA

Gynecologic and Reproductive history:

- Number of Pregnancies? _____ Number of Births? _____
- Last menstrual period
- Hysterectomy? If yes, where the ovaries removed?
- Hormone replacement therapy or contraception (date started, date stopped)

Please give us contact information for your physicians

| Doctor's name | Specialty | Phone number | Other contact information |
|---------------|-----------|--------------|---------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please give us contact information for your pharmacy

| Pharmacy Name | Pharmacy phone number | Comments |
|---------------|-----------------------|----------|
| | | |
| | | |

Your SURGICAL HISTORY: Please list all surgical procedures you have ever had: tonsilectomy, appendectomy, C-section, hysterectomy, heart surgeries, pacemaker/defibrillator placement, spine surgeries, bone surgeries, other surgeries (please describe)

FAMILY HISTORY: Please list all your close relatives in the table below. Feel free to add

| | Diseases | Alive? Current age | Passed away? Age at the time of death |
|--------------------------------|----------|-----------------------|--|
| Father | | | |
| Mother | | | |
| Sister | | | |
| Brother | | | |
| Son | | | |
| Daughter | | | |
| Aunt | | | |
| Uncle | | | |
| Other relatives with cancer | | | |

CURRENT MEDICATIONS: Please list your current medications with doses. We will appreciate if you could provide the name of the prescribing physician.

ALLERGIES: Please describe what kind of allergic reaction you have: rash, trouble breathing, swelling, etc

- Allergies to medications
- Other allergies

PLEASE TELL US ABOUT YOUR LIFE:

- If you are a current or ex-smoker, please record how many years have you been smoking and how many packs you smoked per day. If you quit, please tell us when. If you smoked on and off, count only "on" years.
- How much alcohol do you drink?
- How many people are in your household?
- Do you have anybody to help you with daily routine?
- Are you currently working? What is your occupation?

Do you have any of the following problems?

If the answer is Yes, please click twice on the symptom and give a detailed description below.
If this is an old problem, please tell us when it was first noticed, who is taking care of it and what is being done

General: Fever, Chills, Night sweats, Weight loss

If Yes, Describe

How active are you?

Compared to 6 months ago, do you feel more tired?

Fatigue Scale 0 (no fatigue) 1 2 3 4 5 6 7 8 9 10 (worst ever)

How much time do you spend resting?

Are you able to do your shopping, cooking, cleaning?

Do you take walks?

Do you exercise?

Are you in pain? If yes, please grade the pain on the scale from 0 to 10, describe pain quality(see below)

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

Location:

Quality (mark all that apply): constant, intermittent, burning, crampy

Skin: Rashes, Itching, Dryness, Cracking, Color changes

If Yes, Describe

Ears, Nose, Throat Hearing problems, Ringing in the ears, Visual changes, Sore throat, Mouth sores, Hoarseness, Sinus problems, Running nose

If Yes, Describe

Respiratory: Cough, Wheezing, Shortness of breath, Blood in the sputum

If Yes, Describe

Cardiovascular: Chest pain, Palpitations, Swelling of the limbs or abdomen

If Yes, Describe

Gastrointestinal: Trouble swallowing, heartburn, abdominal pain, diarrhea, constipation, stool changes

If Yes, Describe

Urologic: Pain on urination, Urinary frequency, Excessive urination during the night, Straining on urination, Blood in the urine

If Yes, Describe

Gynecologic: Bleeding, vaginal discharge, dryness, pain during intercourse, other

If Yes, Describe

Breasts: skin changes, nipple changes, nodules/masses, pain

If Yes, Describe

Musculoskeletal: Joint pain, Bone pain, Back pain, Muscle pain or weakness

If Yes, Describe

Neurologic: Headache, Numbness, "Pins and needles", Weakness of extremities, Dizziness, Lightheadedness, Gait disturbances, Hearing or Visual problems

If Yes, Describe

Hematologic/Lymphatic: Easy bruising, "Red dots", Enlarged lymph nodes

If Yes, Describe

Endocrine: Excessive urination, Excessive thirst, Cold or heat intolerance

If Yes, Describe

Psychiatric: Anxiety, depression, panic attacks

If Yes, Describe

Please review and fill **NCCN Distress Thermometer**