CancerCare NORTHWEST

New Patient Questionnaire

Today's Date:___________

What is the reason for your visit today?			
Demographics			
Name:		Date of Birth:	
Home Phone:		Work Phone:	
Occupation:		Employer:	
Date last worked:		Marital Status:	
Name of emergency contact person:			
Emergency contact phone:			
Are we authorized to speak to this person about your condition?			
Are there additional people we **are** authorized to speak to?	YES	(*see line below)*	NO
If **yes,** name of person(s):			
Do you wish to restrict access to your health information?	YES	(*see line below)*	NO
****** If yes, please obtain a *Restriction Request Form* from the receptionist.**			
Where do you live? Home	Home w/caregiver	Assisted Living	Nursing Home
Home Health Care agency/Nursing Home? (If applicable)			
Phone:			
Pharmacy Name:			
Location:		Phone:	
Physician Information			
Referring Physician:			
City/State:		Phone:	
Primary Care Physician:			
City/State:		Phone:	
Other Health Care Providers:			
Radiology History & Allergies			
Have you had previous scans? Include when and where:			
CT:	Date:	Facility:	
MRI:	Date:	Facility:	
PET:	Date:	Facility:	
Other:	Date:	Facility:	
Have you ever had an allergic reaction to IV dye?			
If yes, **was treatment required?**			

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Patient Name ____________________ Account Number ____________________

Drug Allergy	Type of Reaction (Example: Hives)
Allergic to: Latex Tape Iodine Barium IV Contrast (dye)	

Please list all prescriptions and over-the-counter medications that you take, including vitamins and herbs.

Medication/Vitamins/Herbs	Dose	Directions/Frequency (i.e. daily, twice daily, etc.)

Activity Level ("X" one of the levels below)
Fully active, able to carry on all activities without restriction.
Restricted in strenuous physical activity, except ambulatory, and able to carry out work of a light nature, such as light housework or office work.
Walking and capable of self-care, but unable to carry out any work activities. Up and about more than 50% of waking hours.
Capable of only limited self-care. Confined to bed or chair more than 50% of waking hours.
Completely disabled. Cannot carry out self-care. Totally confined to bed or chair.
Do you use equipment to assist with walking or moving?
If so, what type (example: cane, walker, wheel chair)?
Do you have: Dentures Hearing Aids
Review of Systems ("X" if you have experienced *recent* symptoms below)
Have you ever received Chemotherapy before?
Dates:
Facility:
Have you ever received Radiation Therapy before?
Dates:
Facility:
Comments:

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Review of Systems Continued ("X" if you have experienced *recent* symptoms below)	
General	**Eyes**
Fever	Blurred or Double vision
Hot Flashes	Burning or Redness
Night Sweats	Discharge
Appetite Changes	Cataracts
Weight Loss	**ENMT**
Weight Gain	Poor hearing
Insomnia	Sore throat
Sleep disturbances	Nose bleeds
Fatigue	Nasal Congestion
Other:	Dental Problems
Neck	**Genitourinary**
Pain	Dark or bloody urine
Stiffness	Painful urination
Swelling	Increased frequency of urination
Other:	Difficulty starting urine stream
Respiratory	Other:
Shortness of breath	**Lymphatic**
Cough	Swelling lymph nodes
Cough with sputum	Painful lymph nodes
Cough with blood	Other:
Wheezing	**Hematology History**
Use Oxygen? Flow Rate:	Blood clots
Other:	Blood transfusions
Cardiovascular	Abnormal bleeding
Chest pain	Other:
Swollen feet	**Musculoskeletal**
Irregular heart rate	Abnormal swelling- where:
Pounding heart	Muscle pain- where:
Other:	Muscle weakness
Breast	Joint aches
Pain	Other:
Discharge	**Skin**
Lumps/masses	Rash- where:
Redness	Lesions- where:
Other:	Other:
Have you ever had a breast biopsy?	**Neurologic**
If yes, when and where:	Numbness or tingling
Gastrointestinal	Balance changes
Nausea	Headaches
Vomiting	Memory loss
Heartburn	Other:
Indigestion	**Emotional/ Mood**
Constipation	Depressed
Diarrhea	Nervous/ Anxious
Black stools	Tearful
Difficulty swallowing	Other:
Other:	

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Medical Conditions/Diagnoses ("X" if you have *ever* experienced)			
Heart Disease	Cancer	Kidney stones	Seizure
Angina	Chemotherapy	Bladder infections	Cold Sores
Stroke	Radiation	Hepatitis	Depression
High cholesterol	Alcoholism	Glaucoma	
High blood pressure	Arthritis	Migraines	
Diabetes	Osteoporosis	Frequent Headaches	

Please list below any medical conditions not marked above:

Surgery History (type of surgery, date of surgery, and name of hospital/facility)

Have you had a Colonoscopy?	Date:	Where?

For Men Only	
Do you perform testicular self-exams?	Date of last prostate exam?
Date of last testicular exam?	
Have you ever had a PSA drawn?	If yes was it normal?
Comments:	

For Women Only	
Are you having menstrual periods?	Age at the time of your first period?
Number of pregnancies?	Number of children?
Did you breast feed?	Cesarean section(s)? (#)
Do you do breast self-exams?	Date of last mammogram?
Date of last PAP smear?	Age at first pregnancy?
Are you in menopause?	If yes, at what age?
Do you use birth control?	If yes, what?
Have you ever taken hormones?	If yes, what?
Comments:	

Currently, or in the past, have you used any of the following?		
Alcohol:	If yes, how much/ how often?	
Tobacco:	If yes, how many per day?	How many years?
Stopped smoking how many years ago?		
Smokeless tobacco:	If yes, how much?	How often?
Caffeine:	If yes, how much?	How often?
Recreational drugs:		

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Family History					
	IF LIVING			*IF DECEASED*	
RELATIONSHIP	**M/F** Gender	**AGE**	**HEALTH** Good or living with illness	**AGE AT DEATH**	**CAUSE OF DEATH**
Father					
Mother					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Father’s Father					
Father’s Mother					
Mother’s Father					
Mother’s Mother					
Spouse					
Child					
Child					
Child					
Child					
Child					
Child					
Child					

Additional Comments:

Person completing this form (please print) ______________________

Relationship to patient ______________________

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