CancerCare NORTHWEST

New Patient Questionnaire

Today's Date:

What is the reason for your visit today?		
Demographics		
Name:		Date of Birth:
Cell: ( )	Home: ( )	Work: ( )
Email Address:		
Occupation (if retired, list prev. occup.):		Employer:
Date last worked:		Marital Status:
Name of emergency contact person:		
Emergency contact phone:		Relationship:
Are we authorized to speak to this person about your condition? YES NO		
Are there additional people we **are** authorized to speak to about your condition? YES (*see line below)* NO		
If **yes,** name of person(s), include relation and contact phone number:		
Language:	Race:	Ethnicity:
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.**		
Personal Environment		
Support Systems: □ Lives w/spouse, signif other, family or friends □ Lives alone □ Lives in own house		
□ Lives in nursing home □ Lives in assisted living facility □ Incarcerated □ Homeless		
□ Transportation problems exist and will require assistance		
□ Other support system issues:		
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	Approx Start Date	Directions/Frequency (i.e. daily, twice daily, etc.)

Activity Level and Nutrition ("X" one of the levels below)

☐	(0) Fully active, able to carry on all activities without restriction.
☐	(1) No physically strenuous activity, but ambulatory and able to carry out light or sedentary work (e.g. office work, light housework).
☐	(2) Ambulatory/capable of self-care, unable to perform any work activities. Up and about more than 50% of waking hours.
☐	(3) Capable of only limited self-care, confined to bed or chair more than 50% of waking hours.
☐	(4) Completely disabled and totally confined to bed or chair. Cannot carryon any self-care.

Activities: ☐ Sedentary ☐ Daily Activities ☐ Occasional Exercise ☐ Light Exercise

☐ Regular Exercise ☐ Extensive Exercise

Nutrition: ☐ Regular Meals ☐ Nutritional Supplements ☐ Liquid Diet ☐ Other:

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:

Patient Name _____ Account Number _____

Review of Systems Continued ("X" if you have experienced *recent* symptoms below)	
General	**Eyes**
☐ Fever	☐ Blurred or Double vision
☐ Chills	☐ Burning or Redness
☐ Night Sweats	☐ Discharge
☐ Weight Loss	☐ Night blindness
☐ Weight Gain	☐ Visual Difficulties
☐ Sleep disturbances	☐ Light Sensitivity
☐ Fatigue	**ENMT**
☐ Other:	☐ Ear Pain
Endocrine	☐ Nose bleeds
☐ Hot Flashes	☐ Sore Throat/Problems Swallowing
☐ Menstrual Irregularities	☐ Problems Hearing
☐ Other:	☐ Mouth Dryness
Hematologic/Lymphatic	☐ Bleeding Mouth or Gums
☐ Easy Bruising	☐ Ear Infections
☐ Tender or Enlarged Lymph Nodes	☐ Sinus Infections
☐ Blood Clots	☐ Altered Taste
Breast	☐ Ringing in Ears
☐ Breast Pain	**Gastrointestinal**
☐ Breast Mass/Lump	☐ Abdominal Pain
☐ Nipple Discharge	☐ Change in Bowel Habits
☐ Nipple Inversion	☐ Constipation
☐ Other:	☐ Diarrhea
Respiratory	☐ Heartburn
☐ Cough	☐ Nausea
☐ Shortness of Breath	☐ Vomiting
☐ Cough with sputum	☐ Black Stools
☐ Cough with blood	☐ Abdominal cramping
☐ Chest Pain	**Musculoskeletal**
☐ Wheezing	☐ Bone Pain/Where:
☐ Use Oxygen? Flow Rate:	☐ Muscle Pain/Where
Cardiovascular	☐ Joint Pain/Where:
☐ Irregular Heart Rate	☐ Weakness/Where:
☐ Chest Pain	☐ Abnormal swelling/Where:
☐ Abnormal Swelling	☐ Other:
☐ Dizziness with Position Changes	**Skin**
☐ Palpitations	☐ Hair Loss
☐ Other:	☐ Rash/Where:
Genitourinary	☐ Skin Lesions/Where:
☐ Painful Urination	**Neurologic**
☐ Incontinence	☐ Dizziness
☐ Lumps/Masses	☐ Headaches
☐ Vaginal Discharge/Abnormal Bleeding	☐ Disorientation
☐ Urine Changes	☐ Numbness/Tingling-Where:
Emotion/Mood	☐ Seizures
☐ Depression	☐ Nerve Pain/Where:
☐ Anxiety	☐ Memory Loss
☐ Other:	☐ Other:
Medical Conditions/Diagnoses ("X" if you have *ever* experienced)	

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☐ Cancer/Type:	☐ COPD	☐ GERD	☐ Migraines
	☐ Chronic Pain	☐ Glaucoma	☐ MRSA
	☐ Cold Sores	☐ Hematology Disorder	☐ Multiple Sclerosis
☐ Alcoholism	☐ Congestive Heart Failure	☐ Hepatitis/Type:	☐ Obesity
☐ Alzheimer's Disease	☐ Coronary Artery Disease	☐ HIV	☐ Osteoporosis
☐ Anxiety	☐ Dementia	☐ High Cholesterol	☐ Parkinson's
☐ Arthritis/Type:	☐ Depression	☐ High Blood Pressure	☐ Peripheral Neuropathy
☐ Asthma	☐ Diabetes/Type:	☐ High thyroid	☐ Peripheral Vascular Disease
☐ Atrial Fibrillation	☐ Diverticulitis	☐ Low thyroid	☐ Seizure
☐ Benign Prostatic Hypertrophy	☐ Fibromyalgia	☐ Kidney Stones	☐ Stroke
☐	☐ Frequent Headaches	☐ Mental Illness	☐ Tuberculosis

Please list below any medical conditions not marked above:

Surgery History (Indicate Surgery Date and Facility)

☐ AICD Placement	☐ Mastectomy
☐ Appendectomy	☐ Orchiectomy
☐ Bone Marrow Biopsy	☐ Orthopaedic Surgery
☐ Breast Implarts	☐ Pacemaker Placement
☐ Breast Reduction Surgery	☐ Paracentesis
☐ Caesarean Section	☐ Radiation Therapy
☐ Gall Bladder Removal	☐ Splenectomy
☐ Colposcopy	☐ Thoracentesis
☐ Coronary Artery Bypass	☐ Thyroidectomy
☐ Hernia Repair	☐ TubalLigation
☐ Lumbar Puncture	☐ TURP
☐ Lumpectomy	☐ Vasectomy
☐ Mammoplasty	☐

Other Surgeries/Procedures:

Have you had a Colonoscopy? Date: Where?

For Men Only

Patient Name _____ Account Number _____

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

For Women Only

Number of pregnancies:	Age at first menses:
Number of children:	Last Menstrual Period:
Age at first birth:	Menstrual Cycle Length:
# of Interrupted pregnancies:	Menopause status: ☐ Pre ☐ Peri ☐ Post ☐ Unknown
Hormone Use History: ☐ Any Hormone Use ☐ Contraceptive Hormone Use_____ # Years Used ☐ Post-menopause Use _____ # Years Used ☐ Other Hormone Use _____ # Years Used	Age at menopause: Reason for Menopause ☐ Natural ☐ Chemotherapy ☐ Ovaries Removed ☐ Other:
Did you ever breast feed?	Do you do breast self-exams?
Date of last PAP Smear:	Date of last Mammogram:

Additional History

Smoking Status

☐ Yes- current every day smoker
☐ Yes- current some day smoker
☐ Yes- smoker
☐ Yes- but quit
☐ Never

Smoking History

# of Years: _____

# of Packs/Day: _____

# of Years Quit:

Products

☐ Cigarettes
☐ Chewing Tobacco
☐ Pipe
☐ Recreational Drug Use:
☐ Cigars
☐ e-Cigarettes
☐ Snuff
☐ Ilicit Drug Use:

Alcohol Consumption

☐ Yes- current every day drinker
☐ Yes- current occasional drinker
☐ Yes- active
☐ Yes- but quit
☐ Never

Alcohol History

Days/Week: _____

Drinks/Day: _____

Years Quit:

Hazardous Materials

☐ Asbestos
☐ Lead
☐ Radon
☐ Other Hazardous Exposure:
☐ Benzene
☐ Radiation
☐ Other Petroleum Products:

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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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_____ _____

Patient Name Account Number