

**Personal information**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex \_\_\_\_\_

Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Primary care physician \_\_\_\_\_ Phone \_\_\_\_\_

Primary insurance \_\_\_\_\_ Phone \_\_\_\_\_

Insured name \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Secondary insurance \_\_\_\_\_ Phone \_\_\_\_\_

Insured name \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

**Caregiver (primary support person)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Do you have an advance directive or living will?  Yes  No (If you have an advance directive, keep a copy with you so your wishes may be honored)

Do you have a healthcare proxy?  Yes  No

If yes, list name \_\_\_\_\_ Phone \_\_\_\_\_

**Past cancer history**

Have you ever been diagnosed with cancer in the past? If you have, list details of the cancer treatment you received

Type of cancer \_\_\_\_\_

Date diagnosed \_\_\_\_\_

By whom \_\_\_\_\_

Treatment \_\_\_\_\_

Details (if known)

Chemotherapy \_\_\_\_\_

Surgery \_\_\_\_\_

Radiation \_\_\_\_\_

Hormone \_\_\_\_\_

**Current diagnosis**

Type of cancer \_\_\_\_\_ Date \_\_\_\_\_



**Medical history** Please check all that apply to you

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Skin disorder     |
| <input type="checkbox"/> Blood/bleeding disorder   | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Shingles          |
| <input type="checkbox"/> Depression/anxiety        | <input type="checkbox"/> Kidney/bladder problems | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Liver disease           | <input type="checkbox"/> Thyroid problems  |
| <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Lung problems           | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Gynecological problems    | <input type="checkbox"/> Prostate problems       | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Heart disease             |  |  |
- 
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Abdominal pain         | <input type="checkbox"/> Coughing blood                | <input type="checkbox"/> Involuntary weight loss    |
| <input type="checkbox"/> Ankle/leg swelling     | <input type="checkbox"/> Difficulty swallowing         | <input type="checkbox"/> Nose or gum bleeding       |
| <input type="checkbox"/> Balance problems       | <input type="checkbox"/> Dizziness                     | <input type="checkbox"/> Numbness                   |
| <input type="checkbox"/> Black/bloody stools    | <input type="checkbox"/> Easy bruising                 | <input type="checkbox"/> Palpitations               |
| <input type="checkbox"/> Blood in the urine     | <input type="checkbox"/> Fatigue                       | <input type="checkbox"/> Problems urinating         |
| <input type="checkbox"/> Bone pain              | <input type="checkbox"/> Fevers, chills, night sweats  | <input type="checkbox"/> Shortness of breath        |
| <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Fingers turn blue in the cold | <input type="checkbox"/> Substance abuse            |
| <input type="checkbox"/> Change in vision       | <input type="checkbox"/> Frequent nausea/vomiting      | <input type="checkbox"/> Tinnitus (ringing in ears) |
| <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Vomiting blood             |
| <input type="checkbox"/> Cough                  | <input type="checkbox"/> Hoarse voice                  | <input type="checkbox"/> Weakness                   |
- Smoking    packs per day \_\_\_\_\_     Alcohol use    drinks per day \_\_\_\_\_

<b>Menstrual history</b>		Have you ever taken birth control pills or estrogen replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No
Age of onset _____		
Date of last period _____		Pregnancies # _____ Abortions/miscarriages # _____
Post-menopausal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No		Children born alive # _____
Date of last Pap test _____ Results <input type="checkbox"/> Pos <input type="checkbox"/> Neg		Your age when last child was born _____

**Surgical history** (please include all cancer-related procedures)

Type of surgery	Date	Type of surgery	Date





**Allergies**

Reactions	Reactions
<input type="checkbox"/> Penicillin _____	<input type="checkbox"/> CT dye _____
<input type="checkbox"/> Sulfa _____	<input type="checkbox"/> Aspirin _____
<input type="checkbox"/> Morphine _____	<input type="checkbox"/> Tape _____
<input type="checkbox"/> Latex _____	

Other allergies	Reactions

**Family history**

Have any of your relatives had a chronic illness (for example, cancer, heart disease, diabetes)?

Relative	Specify chronic illness(es)	Living	Deceased
Biological mother	_____	<input type="checkbox"/>	<input type="checkbox"/>
Biological father	_____	<input type="checkbox"/>	<input type="checkbox"/>
Maternal grandmother	_____	<input type="checkbox"/>	<input type="checkbox"/>
Maternal grandfather	_____	<input type="checkbox"/>	<input type="checkbox"/>
Paternal grandmother	_____	<input type="checkbox"/>	<input type="checkbox"/>
Paternal grandfather	_____	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	_____	<input type="checkbox"/>	<input type="checkbox"/>
Aunt(s)	_____	<input type="checkbox"/>	<input type="checkbox"/>
Uncle(s)	_____	<input type="checkbox"/>	<input type="checkbox"/>

