

Dear Mercy Cancer Center Radiation Oncology Patient

Welcome to our Department. In order to complete our records, and enable our physicians to ensure that your questions are fully addressed, we appreciate your efforts to complete this intake history form. If you feel any question does not apply to your case, please fill in N/A for “not applicable.”

Name _____

Address _____

Date of Visit _____ / _____ / _____

Date of Birth _____ / _____ / _____

Do you have a “DO NOT RESUSCITATE” Advanced Directive? YES NO

Do we have a copy? YES NO Doctor who signed order _____

Who is accompanying you today? _____

Your Diagnosis: _____

When were you first diagnosed? _____

Summary of your history – Initial symptoms: _____

Biopsy Date / Anatomic location of biopsy _____

Scans, tests and procedures performed to date:

CT: _____

MRI: _____

PET: _____

XRAY: _____

Labs: _____

Treatment received to date (please include surgery and chemotherapy: _____

Previous Radiation Therapy – date, site treated: What facility?

Allergies: (Medication, food, environmental, tape, latex), and TYPE OF REACTION or can't recall.

<u>Allergy</u>	<u>Reaction</u>	<u>Circle Severity of Reaction</u>
		Mild - Moderate - Severe
		Mild - Moderate - Severe
		Mild - Moderate - Severe
		Mild - Moderate - Severe
		Mild - Moderate - Severe

Medications (prescription, over-the-counter, vitamins, herbal, hormones, chemotherapy):

Medication	Dose	How Often	Reason Taken
Chemotherapy Drug:	Date of last dose:	Medical Oncologist:	

Height: ____ ft. ____ in. Weight: ____ lb. T: ____ P: ____ R: ____ B/P: ____ O2Sat ____

Preferred Pharmacy? _____

Past Medical History – previous and current medical problems, list approximate date of diagnosis:

Past Surgical History – approximate year of procedure: _____

Social History:

Where were you born? _____

What type of work did / do you do? _____

Marital Status: SINGLE MARRIED DIVORCED WIDOWED

With whom do you live? _____

Do you have children? If yes, gender, ages, where they reside:

Do you use tobacco products now or in the past? YES NO

If yes: # of years _____ # packs per day _____ when quit _____

Do you use recreational drugs? _____

How much alcohol do you consume in a week _____

Do you have a family history of cancer? If yes, please elaborate relationship and type of cancer:

Relationship	Type of Cancer

NCCN Distress Thermometer for Patients:
“How distressed are you on a scale of 1 to 10?”

10	Extreme
9	Frightening
8	Horrible
7	Awful
6	Dreadful
5	Really Bad
4	Uncomfortable
3	Bothersome
2	Annoying
1	Mild
0	No distress

Please circle the number that best describes how you feel right now?

Review of Systems

Pain Assessment	Yes	No	Comments
Pain Intensity-Current			Scale of 1-10:
Pain Location			
Pain Control Medications			

Constitutional Symptoms	Yes	No	Comments
Fever			
Weight Loss			
Loss of Appetite			
Fatigue			
Other Symptoms			

Eyes	Yes	No	Comments
Vision Changes			
Double Vision			
Blurry Vision			
Prescribed Eyewear			Glasses Contacts Both
Additional Notes: Eyes			

Ears, Nose, Mouth, Throat	Yes	No	Comments
Mouth Sores			
Trouble Swallowing			
Hoarseness			
Ear Pain			
Dentures			Upper Full Partial Lower Full Partial
Additional Notes: ENT			

Cardiovascular	Yes	No	Comments
High Blood Pressure			
Low Blood Pressure			
Chest Pain			
Heart Attack			
Pacemaker			
Defibrillator			
Implant Card			Please provide for copy
Stroke			
Edema/Swelling			Location
Additional Notes: Cardiovascular			

Respiratory	Yes	No	Comments
Shortness of Breath			
Cough			
Cough-Productive			
Cough-Color			
Cough-Amount			
Sleep Apnea?			C-Pap?
OXYGEN USE?			How much: How often:

Gastrointestinal	Yes	No	Comments
Nausea			
Vomiting			
Diarrhea			
Constipation			
Blood in Stools			
Abdominal Pain			
Jaundice			
Additional Notes: GI			

Urination	Yes	No	Comments
Blood in Urine			
Burning with Urination			
Night time Urination			How many times :
Urgency			
Urinary Frequency			
Urinary Incontinence			
Additional Notes: GU			

Musculoskeletal	Yes	No	Comments
Bone Pain			
Arthritis			
Additional Notes: Musculoskeletal			

Skin	Yes	No	Comments
Skin Lesions/Lumps			
Sores			
Rash			
Surgical Incisions			
Breast Lumps			
Nipple Discharge			
Additional Notes: Integumentary			

Neurologic	Yes	No	Comments
Headache			
Numbness/Weakness-Arms			
Numbness/Weakness-Legs			
Additional Notes: Neurologic			

Psychiatric	Yes	No	Comments
History of treated psych disease			
Additional Notes: Psychiatric			

Endocrine	Yes	No	Comments
Diabetes			
Diabetes controlled by:			
Thyroid problems			
Additional Notes: Endocrine			

Blood /Lymphatic	Yes	No	Comments
Bruising/Bleeding			
Large nodes			
Additional Notes: Hematologic/Lymphatic			

Allergic/Immunologic	Yes	No	Comments
History of Lupus			
History of Autoimmune Disease			
Scleroderma			
Rheumatoid Arthritis			
Collagen Vascular Disease			
Additional Notes: Allergic/Immunologic			

Gynecologic (Females)	Comments		
Number of Pregnancies			
Number of Deliveries			
Vaginal Bleeding	Yes	No	
1 st Menstrual Cycle Age			Age:
Menopause Age			Age:
Hormone Replacement Therapy	Yes	No	Medication:
Hormone Therapy Started	-----	-----	Date:
Contraception:			Medication Name/ Date Started
Birth Control Pills			
Devices –IUD – release hormones			
Implants that release hormones (i.e. Nexplanon)			
Additional Notes: Gynecologic			

AUA Prostate Cancer Assessment (American Urological Association) (Males)

Please write down a frequency/score you experience for each symptom:

Frequency of Occurrence	Score		Symptom	Your Score
Not at all	0		Sensation of bladder not empty	
Less than 1 time in 5	1		Urinate less than 2 hours after the last	
Less than half the time	2		Multiple stop/ starts when voiding	
About half the time	3		Difficult to postpone voiding	
More than half the time	4		Weak urinary stream	
Almost always	5		Push/ strain to begin urination	
			Number of times per night up to urinate	#

Which doctors /care providers would you like to receive your records? (Family physician, medical oncologist, and surgeon)?

Thank you for completing this form. Please let us know if we can be of assistance at any time.

Mercy Cancer Center Radiation Oncology Physicians and Staff