

# Connecticut Oncology & Hematology

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Today's Date \_\_\_\_\_

Language \_\_\_\_\_ Secondary \_\_\_\_\_

*PLEASE PRINT AND COMPLETE TO THE BEST OF YOUR ABILITY*

PERSON TO NOTIFY IN CASE OF EMERGENCY	
Name	Relationship
Home Phone	Work Phone
Name	Relationship
Home Phone	Work Phone
PLEASE LIST <u>ALL</u> HEALTH CARE PROVIDERS THAT CARE FOR YOU	
Name	Phone
Address	
Name	Phone
Address	
Name	Phone
Address	
Name	Phone
Address	
MEDICATION INFORMATION	
Pharmacy	Phone
Address	
<i>List all medications you are taking at this time: (Please include dosage and how you take it; include prescriptive, over-the-counter meds, vitamins and herbal supplements.)</i>	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Allergies to Medication: <i>(list names of drugs which you are allergic to and what happened)</i>		
Medications	<input type="checkbox"/> Y <input type="checkbox"/> N	List:
Environmental Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	List:
Food	<input type="checkbox"/> Y <input type="checkbox"/> N	List:
Shellfish	<input type="checkbox"/> Y <input type="checkbox"/> N	List:
Latex	<input type="checkbox"/> Y <input type="checkbox"/> N	List:

# Why are you here today?

## MEDICAL HISTORY: Do you have or have you had: (Please check appropriate boxes)

	YES	NO		YES	NO		YES	NO
Diabetes			Stomach Problems			Lung Problem		
High Blood Pressure			Colitis			Bleeding Problems		
Heart Problem			Kidney Disease			Hormone Therapy		
Stroke			Anemia			Tuberculosis		
Cataracts/Glaucoma			Hepatitis			Previous Radiation		
Cancer			Arthritis			Stomach Ulcers		

### Other problems not listed:


If diagnosed previously with cancer, list site(s) of cancer:

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Surgeries/Procedures:	Date (month/year)	Hospital

### Family History - list any family member(s) who have had cancer or any disorders common in your family:

1.	4.
2.	5.
3.	6.

### Social History:

Employed Yes\_\_\_\_\_ No\_\_\_\_\_ Occupation \_\_\_\_\_

Do you drink alcohol? Yes\_\_\_\_\_ No\_\_\_\_\_ Amount/Type \_\_\_\_\_

Do you smoke cigarettes or chew tobacco? Yes\_\_\_\_\_ No\_\_\_\_\_ How many years? \_\_\_\_\_ Packs per day? \_\_\_\_\_

When did you quit if you used tobacco products in the past? \_\_\_\_\_

Use or have used recreational drugs? Yes\_\_\_\_\_ No\_\_\_\_\_

### Please complete the following questions. Have you noticed any recent... Comments

	Yes	No	Amount gain_____ loss_____ since_____
Weight gain or loss			
Night sweats			
Fever			
Loss of appetite			
<b>Skin</b>			
Itchy skin			
Rash			
Jaundice (yellowing of skin)			
<b>Eyes</b>			
Double vision			
Blurred vision			
Wear glasses / corrective lenses			
Eye pain			
<b>Ears / Nose</b>			
Change in hearing			
Frequent ear infections			
Buzzing or ringing in the ears			
Sinus problems			
Recurrent nose bleed			
<b>Mouth / Throat</b>			
Lumps in neck			
Pain in the mouth			
Hoarse voice			
Difficulty/pain in swallowing			
Mouth sores			
Taste change			
Do you wear dentures?			

<b>Respiratory System/Cardiovascular System:</b>			
How many blocks can you walk before you are out of breath?	1	2	3 >3
Has this changed recently?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
			<b>Comments</b>
Persistent Cough	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cough up blood	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ankle swelling	Yes <input type="checkbox"/> No <input type="checkbox"/>	Irregular heartbeat	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chest pains	Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pacemaker defibrillator	Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Musculoskeletal System:</b>			<b>Comments:</b>
Bone pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint Swelling	Yes <input type="checkbox"/> No <input type="checkbox"/>
Muscle weakness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint stiffness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Joint pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Muscle pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Neurological System:</b>			<b>Comments:</b>
Weakness in a limb	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anxiety	Yes <input type="checkbox"/> No <input type="checkbox"/>
Headache	Yes <input type="checkbox"/> No <input type="checkbox"/>	Depression	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>	Numbness/tingling	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blurred vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Personality changes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Problems remembering	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blacking out	Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty speaking	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lose balance	Yes <input type="checkbox"/> No <input type="checkbox"/>
Inability to sleep	Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Gastrointestinal System:</b>			<b>Comments:</b>
Black stool	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diarrhea	Yes <input type="checkbox"/> No <input type="checkbox"/>
Excessive constipation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nausea/vomiting	Yes <input type="checkbox"/> No <input type="checkbox"/>
Abdominal pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood in stool	Yes <input type="checkbox"/> No <input type="checkbox"/>
How many bowel movements per day?		Bowel control problem	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Frequent heartburn? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Genitourinary System:</b>			
Painful urination	Yes <input type="checkbox"/> No <input type="checkbox"/>	Leakage/loss of urine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty emptying bladder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Difficulty starting urination	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood in urine	Yes <input type="checkbox"/> No <input type="checkbox"/>	Frequent urination	Yes <input type="checkbox"/> No <input type="checkbox"/>
Urgency to urinate without warning			Yes <input type="checkbox"/> No <input type="checkbox"/>
How many times do you get up at night to urinate?			
Have you noticed any change in sexual function over the last 2 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Hematology:</b>			
Hx blood transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, why?	when?
Hx of clotting disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Any problem with bleeding (bleeding disorder)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do you take aspirin or any blood thinners regularly	Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>For male patients only</b>			
Date last testicular exam:		Last prostate exam:	
<b>For Women:</b>			
Age of first menses:			
Have you ever been pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If so, how many times?	
Have you gone through menopause?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If so, how old were you?	
Have you had any bleeding or discharge from the vagina?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do you have any lumps, swelling or tenderness of the breasts?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do you have pain or bleeding with sexual intercourse?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do you have heavy menstrual periods?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Chance of pregnancy?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Date of last menstrual period:		Date of last pap smear:	
Date of last breast exam:		Date of last mammogram:	

<b>PAIN MANAGEMENT:</b>	
Do you have pain?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, where is your pain located?	
What relieves your pain?	medication _____ position change _____ meditation _____ other _____
Please circle the number that best describes your pain.	1 2 3 4 5 6 7 8 9 10 No Pain Moderate Pain Worse Possible Pain
What is your pain goal to maintain your quality of life?	
<b>FUNCTIONAL ASSESSMENT:</b>	<b>COMMENTS</b>
Do you have any difficulty caring for yourself?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you live alone?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have any difficulty preparing meals or shopping?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have any transportation concerns?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you use a <input type="checkbox"/> cane <input type="checkbox"/> walker <input type="checkbox"/> wheelchair	
<b>HOME CARE NEEDS:</b>	
Are you currently receiving services at home:	
Visiting Nurse	Yes <input type="checkbox"/> No <input type="checkbox"/> Who is provider _____
Meals on wheels	Yes <input type="checkbox"/> No <input type="checkbox"/>
Oxygen	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, number of liters/minute _____
Home IV services	Yes <input type="checkbox"/> No <input type="checkbox"/> Who is provider _____
Hospice	Yes <input type="checkbox"/> No <input type="checkbox"/> Who is provider _____
Do you feel safe at home	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>MISCELLANEOUS:</b>	
Do you have any financial concerns?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a Living will or Advanced Directive? (If yes, please provide us with a copy for your record)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Would you like information about them?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have any spiritual, religious or cultural practices which may impact your health care?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe:	
<b>LEARNING NEEDS:</b>	
To assist us in teaching you about your care and therapy, please answer the following questions. You learn best by: _____ Reading _____ Hearing _____ Seeing _____ Doing _____	
Do you have any barriers to learning: _____ Physical _____ Emotional _____ Language _____ Thinking _____ _____ Reading _____ Hearing _____ Writing _____ Financial _____ Vision _____ Cultural _____ Spiritual _____	

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APRN or Physician Signature / Date