COMPREHENSIVE
CANCER CENTERS

CCCN Patient Questionnaire

Date: _____

Patient Name: _____ Age: _____

Referred by: _____ Primary Care Physician:_____

Please provide names and phone numbers of your physicians *(primary care, medical oncologist, surgeon, etc.)*:

_____

_____

Reason for visit: _____

Please list problems that led you to seek medical attention here? _____

_____

Medical History

Have you ever had chemotherapy? Yes No If so, provide date and place: _____

Have you ever had radiation therapy, radiation implants, cobalt treatment, etc? Yes No

If yes, please provide location, dates, and phone numbers of center where you were treated: _____

_____

Have you had any accidents or injuries of serious consequence? Yes No

If yes, please list: _____

_____

Childhood Diseases: _____

Previous Transfusion: Yes No If yes, did you have a reaction? Yes No

What was the reaction?

_____

Have you been in the hospital recently? Yes No If yes, when were you admitted *(date)*?_____

Hospital?_____ Reason for admission: _____

Please check if you have a history of, or currently have any of the following:

	Yes	No
Arthritis		
Back Pain		
Bronchitis		
Congestive Heart Failure		
Diabetes		
Emphysema (COPD)		
Heart Attack		
Hepatitis B or C		
High Blood Pressure		
HIV		
Kidney Disease		
Liver Disease		
Lung Problems		
Other Heart Disease		

	Yes	No
Pacemaker		
Pain: location_____		
mild moderate severe		
Previous Cancer Type		
Phlebitis		
Seizures		
Skin Disease		
Stomach Ulcers		
Thyroid Disease		
Tuberculosis		
Other *(medical history not listed elsewhere)*:		

Surgery History

Surgery	Date	Age

Current Medications

Medication	Dose	Frequency

Please list any drug allergies:

_____

_____

Family History

Family Member	Living/Age	Deceased/Age	Cause of Death	List any Cancers	List Other Medical Problems
Father					
Mother					
Brothers					
Sisters					

Any family members with cancer detected before age 50? _____

Please list any other family members who have had cancer:

Name/Age	Relationship	Cancer Type
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Are you currently: employed retired unemployed on disability

Occupation:_____

Marital Status: single married divorced widowed separated

Current Living Situation: alone spouse significant other other friend parent child

Occupation of others in the household: _____

Children: # of sons _____ ages _____ any illness _____

# of daughters _____ ages _____ any illness _____

Have you ever smoked? Yes No If yes, what was your age when you started? _____

Average packs per day: _____ Date quit (if applicable): _____

Do you drink alcohol? Yes No If yes, what type? _____

How much per week? _____

Did you ever drink large amounts of alcohol? Yes No Date quit (if applicable): _____

Screening Exams

Date of last mammogram: _____ Results: Normal Abnormal

Date of last bone density/osteoporosis scan: _____ Results: _____

Date of last Colonoscopy: _____ Results: Normal Abnormal

Other imaging studies (i.e. CT scan, MRI, PET): _____

Where do you have your scan/imaging studies done? _____

Prostate History (Men Only)

Last PSA: _____ Last prostate exam: _____

Do you have impotence? Yes No Partial Total

OB/GYN History (Women Only)

Date of last menstrual period: _____ Last pap smear: _____

Are you currently pregnant? _____ Could you be pregnant? _____

Pregnancies: _____ # Live births _____ Age at first pregnancy: _____

Age of Menopause: _____ History of birth control of hormone replacement? Yes No If yes, how long were you on the medication: _____ Name of medication: _____

Review of Systems

Please mark only the symptoms you've experienced within the last month*

General	Yes	No		Eyes	Yes	No
Fatigue				Blurred vision		
Fevers				Cataracts		
Night sweats				Double vision		
Poor appetite				Glaucoma		
Weight gain # pounds				Floaters		
Weight loss # pounds				Vision Loss		

Cardiovascular	Yes	No		Pulmonary System	Yes	No
Ankle swelling				Cough		
Calf pain				Coughing blood		
Chest pain				Pain with breathing		
Heart murmur				Shortness of breath		
Light headed feeling				Sputum		
Palpitations				Wheezing		

Gastrointestinal	Yes	No		Nervous System	Yes	No
Abdominal pain				Dizziness		
Black stool				Headaches		
Blood in stool				History of seizures		
Clay colored stool				History of stroke		
Constipation				Loss of sensation		
Diarrhea				Mental Illness		
Difficulty swallowing				Paralysis		
Heartburn				Passing out		
Nausea				Speech disturbance		
Vomiting blood				Tremors		
Vomiting				Weakness of arm/leg		
Yellow skin (Jaundice)						

Have you ever had a colonoscopy? Yes No If yes, when? _____

Head and Neck	Yes	No		Genitourinary System	Yes	No
Difficulty swallowing				Blood in the urine		
Dry mouth				Frequent Urination		
Hearing loss				Incontinence		
Hoarse voice				Night time urination		
Mouth pain/ulcers				Pain with urination		
Nose bleeds				Retention of urine		
Post nasal drip				Urgent Urination		
Sinusitis/sinus pain						

Date of last dental exam: _____

How many times per night do you wake up from sleep to urinate? _____

Musculoskeletal System	Yes	No		Hematologic	Yes	No
Arm or leg swelling				Bruising		
Arthritis				Enlarged lymph nodes		
Back pain				Gum or nose bleeding		
Bone pain				History of blood transfusion		
Muscle pain				Treatment for anemia		
Red or swollen joints				Abnormal bleeding (with surgery)		

GYN	Yes	No			Yes	No
Vaginal Bleeding				Vaginal Discharge		

COMPREHENSIVE CANCER CENTERS

LIMITED ENGLISH PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES FOR NEVADA

ATTENTION: If you speak any of the following languages, language assistance services, free of charge, are available to you. Call 1-877-261-6608 for more information.

Amharic:	**Arabic**
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-261-6608	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن 1-877-261-6608 رقم) اتصل برقم .خدمات المساعدة اللغوية تتوافر لك بالمجان .(877-261-6608 1-هاتف الصم والبكم:
Chinese:	**French:**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-261-6608。	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-261-6608.
German:	**Ilocano:**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-261-6608.	PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-877-261-6608.
Japanese:	**Korean:**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-261-6608 まで、お電話にてご連絡ください。	*주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.* 1-877-261-6608
Russian:	**Samoan:**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-261-6608.	MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-877-261-6608.
Spanish:	**Tagalog:**
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-261-6608.	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-261-6608.
Thai:	**Urdu:**
เรียน ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-261-6608	ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-261-6608
Vietnamese:	
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-261-6608.	