

Date: _____

CCCN Patient Questionnaire

Patient Name: _____ Age: _____

Referred by: _____ Primary Care Physician: _____

Other Physician(s): _____

Reason for visit: _____

Problems that have led patient to seek medical attention here? _____

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

Medical History

Have you ever had chemotherapy? If so, given 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 has 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		Yes	No
Arthritis			Lung Problems		
Back Pain			Other Heart Disease		
Bronchitis			Pacemaker		
Congestive Heart Failure			Pain: location _____		
Diabetes			mild moderate severe		
Emphysema (COPD)			Previous Cancer Type		
Heart Attack			Phlebitis		
Hepatitis B or C			Seizures		
High Blood Pressure			Skin Disease		
HIV			Stomach Ulcers		
Kidney Disease			Thyroid Disease		
Liver Disease			Tuberculosis		

Surgery History

<u>Surgery</u>	<u>Date</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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					

Prostate History (men only)

Last PSA: _____ Last prostate exam: _____

Do you have impotence? Yes No Partial Total

Screening Exams

Date of last mammogram: _____ Results: Normal Abnormal

Date of last done 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? _____

Review of Systems

General	Yes	No	Eyes	Yes	No
Fatigue			Blurred vision		
Fevers			Cataracts		
Night sweats			Double vision		
Poor appetite			Glaucoma		
Weight gain # pounds			Floater		
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
Vaginal bleeding		
Vaginal discharge		

For Office Use Only:

Wt: _____ Ht: _____ BSA: _____ B/P: _____

T: _____ P: _____ R: _____ O2Sat: _____

Date: _____

RN/MA: _____