Today's Date _____

COMPREHENSIVE CANCER CENTERS

Patient Questionnaire

Patient Name: _____ Age: _____

Referred by: _____ Primary Care Physician: _____

OB/GYN: _____ Surgeon: _____

Other Physicians: _____

Problems that have led patient to seek medical attention here (check)?

___ Abnormal mass/lump ___ Abnormal breast mass/lump ___Abnormal scan/mammogram

___ Poor breathing ___ Cough ___ Pain ___Weight Loss ___ Abnormal Lab

Other:

_____

Medical History

Please check if you have a history of any of the following

	Yes	No			Yes	No
Heart attack				Congestive heart failure		
Kidney disease				Other heart disease		
Liver disease				High blood pressure		
Tuberculosis				Lung problems		
Seizures				Thyroid disease		
Diabetes				Phlebitis		
Emphysema/COPD				Stomach problems		
Arthritis				Skin disease		
Previous Cancer Type?				Pain: location _____ Mild: ___ Moderate: ___ Severe: ____		

Surgical History

Surgeries	Date	Surgeries	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous Transfusions yes___ no___ Transfusion reaction yes___ no___

Allergies

Medication(s) = allergic reaction

1._____=_____ 2._____=_____ 3 ._____=_____

Current Medications

Medication	Dose	Frequency	Medication	Dose	Frequency
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Family History

Family Member	Living/Age	Deceased/Age	Health Status or Cause of Death
Father			
Mother			
Brothers #			
Sisters #			

Please list any other family members who have had cancer and type of cancer:

_____

_____

Social History

Are you currently: Employed Retired Unemployed On Disability

Occupation: _____

Circle one: Single Married Divorced Widowed Separated

Occupation of others in household: _____

Children: # of Sons: ____ Ages: _____ Illness: _____

# of Daughters: ____ Ages: _____ Illness: _____

Have you ever smoked? _____ If yes, your age when you started: _____

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

Do you drink alcohol? _____ What type: _____ How much per week? _____

Did you ever drink large amounts of alcohol? _____ Date quit (if applicable): _____

GYN/OB History (women only)

Date of last menstrual period _____ Last Pap smear _____

Last mammogram _____ Last bone density/osteoporosis scan _____

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

Pregnancies ____ # Live births _____ Age at first pregnancy _____ Age at menopause _____

Birth control pills? Yes___ No____ Name _____ Dates _____

Fertility medicines? Yes___ No____ Name _____ Dates _____

Hormone Medicine

Replacement therapy? Yes___ No____ Name _____ Dates _____

Review of Systems

General	Yes	No			
Hot flashes			Fatigue		
Fevers			Night sweats		
Weight gain # pounds			Weight loss # pounds		
Poor appetite					

Eyes	Yes	No			
Cataracts			Double vision		
Blurred vision			Glaucoma		
Vision Loss			Floaters		

Head and Neck	Yes	No			
Mouth pain/ulcers			Post nasal drip		
Sinusitis/sinus pain			Hearing loss		
Difficulty swallowing			Hoarse voice		

Cardiovascular	Yes	No			
Chest pain			Heart murmur		
Palpitations			Ankle swelling		
Calf pain			Light headed		

Pulmonary System	Yes	No			
Cough			Shortness of breath		
Coughing blood			Pain with breathing		
C-PAP			Wheezing		
Sputum					

Gastrointestinal	Yes	No			
Nausea			Yellow skin (Jaundice)		
Vomiting			Clay colored stool		
Constipation			Blood in stool		
Diarrhea			Abdominal pain		
Vomiting blood			Black stool		
Difficulty swallowing			Heartburn		
Colonoscopy			Date of colonoscopy _____ Normal? _____		

GYN	Yes	No			
Vaginal Discharge			Vaginal bleeding		

Nervous System	Yes	No			
Headaches			History of stroke		
Dizziness			History of seizures		
Paralysis			Speech disturbance		

	Yes	No		Yes	No
Tremors					
Loss of sensation			Weakness of arm/leg		
Mental Illness			Passing out		
Tremors					

Musculoskeletal System	**Yes**	**No**		**Yes**	**No**
Arthritis			Red or swollen joints		
Bone pain			Muscle pain		
Spine pain			Arm or leg swelling		

Hematologic	**Yes**	**No**		**Yes**	**No**
Gum or nose bleeding			Treatment for anemia		
Enlarged lymph nodes			Bruising		

Genitourinary System	**Yes**	**No**		**Yes**	**No**
Pain with urination			Urgent urination		
Blood in urine			Incontinence		
Frequent urination			Night time urination _____X		

B/P: _____ T: _____ P: _____ R: _____ Wt: _____ Ht: _____ BSA: _____ O2Sat: _____

Date:_____ RN/MA: _____

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**
ትኩረት: እርስዎ የ አማርኛ ተናጋሪ ከሆኑ የቋንቋ ድጋፍ አገልግሎቶች ያለ ክፍያ በነጻ ተዘጋጅልዎታል:: በ1-877-261-6608 ይደውሉ::	ملحوظة: إذا كنت تتحدث اللغة العربية، تتوافر لك خدمة المساعدة اللغوية بالمجان. برجاء الاتصال بـ 1-877-261-6608.
Chinese:	**French:**
注意：如果您讲中文，我们可以为您提供免费语言协助服务。请拨打 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. Rufen Sie 1-877-261-6608.	PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan iti 1-877-261-6608.
Japanese:	**Korean:**
ご注意：日本語でお話しになりたい場合は、無料の言語支援サービスをご利用いただけます。1-877-261-6608にお電話ください。	*안내: 한국어 통역지원서비스를 무료로 제공해드리고 있습니다. 지원이 필요하시면, 전화* 1-877-261-6608로 문의하시기 바랍니다.
Russian:	**Samoan:**
ВНИМАНИЕ: Если вы говорите по-русски, вам предложены бесплатные услуги перевода. Звоните по телефону 1-877-261-6608.	FAAALIGA: Afai e te tautala Faa-Samoa, o loo maua fesoasoani mo tautua tau gagana, e lē totogia mo oe. Telefoni i le 1-877-261-6608.
Spanish:	**Tagalog:**
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llamar al 1-877-261-6608.	ATENSYON: Kung nagsasalita ka ng Tagalog, ang mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit mo. Tumawag 1-877-261-6608.
Thai:	**Urdu:**
โปรดทราบ: หากคุณพูดภาษาไทย บริการให้ความช่วยเหลือด้านภาษาพร้อมให้บริการแก่คุณโดยไม่มีค่าใช้จ่าย โทร 1-877-261-6608	**توجہ: اگر فارسی صحبت می‌کنید، خدمات ترجمہ بہ صورت رایگان در اختیارتان قرار می‌گیرد. با 1-877-261-6608 تماس بگیرید.**
Vietnamese:	
CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Hãy gọi 1-877-261-6608.	