



COMPREHENSIVE
CANCER CENTERS

Patient Questionnaire

Name: _____ Date of consultation _____

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.)

Past Medical History

Chemotherapy: Have you ever had a chemotherapy? If so, list date and place.

Radiation Therapy: Have you ever had radiation therapy, radiation implants, cobalt treatment etc.? **Yes** or **No** (If yes, please provide location, dates and phone numbers or center where you were treated.)

Surgery: Please list **all** previous surgeries that you have had along with your approximate age to that time:

Accidents: Have you ever had any accidents or injuries of serious consequence? Yes or No – Please list:

Recent Hospitalizations: _____

Childhood Diseases: _____

Current Medication (Please list): _____

Medication Allergies (Please list): _____

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

Diabetes	Yes	No	Heart Trouble	Yes	No
Kidney Disease	Yes	No	Phlebitis	Yes	No
Liver Disease	Yes	No	High Blood Pressure	Yes	No
Rheumatic Fever	Yes	No	Bronchitis	Yes	No
Seizures	Yes	No	Thyroid	Yes	No
Tuberculosis	Yes	No	Back Pain	Yes	No
Emphysema	Yes	No	Stomach Ulcers	Yes	No
Rheumatoid Arthritis	Yes	No	Skin Disease	Yes	No

Family History:

	Alive	Age of Death or Current Age	Cause of Death	List any cancers	Significant Medical Problems
Father	Yes No				
Mother	Yes No				
Any family members with cancer detected before age 50?					

Please list any other family members who have had cancer:

Breast Cancer	Who:	Other:
Ovarian Cancer	Who	Other:
Colon Cancer	Who:	Other:
Prostate Cancer	Who:	Other:

Social History:

Are you currently: Employed Retired Unemployed On Disability

Occupation: (current or former) _____

Marital Status: Single Married Divorced Widowed Separated

Current Living Situation: (circle all that apply)

Alone With Spouse Significant Other Friend Parent Child Other Relative

Children: # of Males _____ Ages _____ # of Females _____ Ages _____

Have you ever smoked? YES or NO If yes your age when you started _____

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

Do you drink alcohol YES or NO What type _____

How much per week _____

Did you ever drink large amounts of alcohol? YES or NO Date quit (if applicable) _____

Review of Systems: Do you currently suffer from any of the following symptoms?

General:

Fevers	YES	NO	Night Sweats	YES	NO
Poor Appetite	YES	NO	Weight Loss How many pounds	YES	NO

Head and Neck:

Hearing Loss	YES	NO	Nose Bleeds	YES	NO
Dry Mouth	YES	NO	Hoarse voice	YES	NO
Cataracts	YES	NO	Glaucoma	YES	NO

Cardiovascular:

Chest pain with effort	YES	NO	Heart Murmur	YES	NO
Palpitations	YES	NO	Ankle Swelling	YES	NO

Pulmonary System:

Cough	YES	NO	Shortness of Breath	YES	NO
Coughing Blood	YES	NO	Pain with Breathing	YES	NO

Gastrointestinal System:

Nausea	YES	NO	Yellow Skin (Jaundice)	YES	NO
Vomiting	YES	NO	Clay Colored Stool	YES	NO
Constipation	YES	NO	Blood in the Stool	YES	NO
Diarrhea	YES	NO	Abdominal Pain	YES	NO
Have you ever had a colonoscopy?			If yes, when?		

Nervous System:

Headaches	YES	NO	Tremors	YES	NO
Dizziness	YES	NO	History of Stroke	YES	NO
Paralysis	YES	NO	History of Seizures	YES	NO
Loss of Sensation	YES	NO	Speech Disturbance	YES	NO
Mental Illness	YES	NO	Weakness of an Arm/Leg	YES	NO

Musculoskeletal System:

Arthritis	YES	NO	Limited Motions	YES	NO
Back Pain	YES	NO	Muscle Cramps	YES	NO

Hematological:

History of Blood Transfusion	YES	NO	Treatment for Anemia	YES	NO
Any History of abnormal bleeding (i.e. With surgeries or dental work)			YES	NO	

Genitourinary System:

Pain with Urination	YES	NO	Urgent Urination	YES	NO
Blood in the Urine	YES	NO	Incontinence	YES	NO
Frequent Urination	YES	NO	Retention of Urine	YES	NO

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

(FOR MEN ONLY)

Do you have impotence? (circle one) Yes No Partial Total

(FOR WOMEN ONLY)

Date of last menstrual period _____

Date of last mammogram _____

Number of pregnancies _____

Number of deliveries _____

Age of first pregnancy _____

History of C-sections _____

Age of Menopause _____

Hormonal Therapy? Yes No Previous Current

Are you Currently Pregnant? Yes No Unsure

Could you possibly be pregnant? Explain _____



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: ትኩረት: እርስዎ የ አማርኛ ተናጋሪ ከሆኑ የቋንቋ ድጋፍ አገልግሎቶች ያለ ክፍያ በነጻ ተዘጋጅልዎታል። በ1-877-261-6608 ይደውሉ።	Arabic ملحوظة: إذا كنت تتحدث اللغة العربية، تتوفر لك خدمة المساعدة اللغوية بالمجان. برجاء الاتصال بـ 1-877-261-6608.
Chinese: 注意：如果您□中文，我□可以□您提供免□□言□助服□。□□打 1-877-261-6608。	French: ATTENTION : Si vous parlez français, des services d'aide linguistique, vous sont proposés gratuitement. Appelez le 1-877-261-6608.
German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-877-261-6608.	Ilocano: 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: 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。	Korean: 안내: 한국어 통역지원서비스를 무료로 제공해드리고 있습니다. 지원이 필요하시면, 전화 1-877-261-6608로 문의하시기 바랍니다.
Russian: ВНИМАНИЕ: Если вы говорите по-русски, вам предложены бесплатные услуги перевода. Звоните по телефону 1-877-261-6608.	Samoan: FAAALIGA: Afai e te tautala Faa-Samoa, o loo maua fesoasoani mo tautua tau gagana, e lē togotogia mo oe. Telefoni i le 1-877-261-6608.
Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llamar al 1-877-261-6608.	Tagalog: 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: โปรดทราบ: หากคุณพูดภาษาไทย บริการให้ความช่วยเหลือด้านภาษาพร้อมให้บริการแก่คุณ โดยไม่มีค่าใช้จ่าย โทร 1-877-261-6608	Urdu: توجہ: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان در اختیارتان قرار می گیرد. 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.	