PATIENT INITIAL HISTORY QUESTIONNAIRE

Name:		Date of Birth:	Age: Race:
Street:			
City, State, Zip:	Referring Physician		
Day Phone:	Medical Oncologist		
Work Phone:	Family Physician		
Cell Phone:	Other Physicians		
Emergency contact and phone:			

Do you have an Advance Directive (Do Not Resuscitate)? ❒ No ❒ Yes (please provide us a copy)

Allergies to medications? ❒ No ❒ Yes: _____

Allergies to IV iodine contrast? ❒ No ❒ Yes: _____

Medications, dose, frequency (or provide list): _____

_____

_____

Prior history of other cancers? ❒ No ❒ Yes: _____

Prior radiation treatment? ❒ No ❒ Yes: _____

Prior chemotherapy? ❒ No ❒ Yes: _____

Are you pregnant, or still want to have children? ❒ No ❒ Yes: _____

Do you have a pacemaker or defibrillator? ❒ No ❒ Yes: _____

Do you have lupus or scleroderma? ❒ No ❒ Yes: _____

If you have a head-or-neck cancer, who is your dentist? _____

Patient Name:_____

Please list any other medical conditions that you have:

❒	Diabetes	❒	Arthritis
❒	High blood pressure	❒	Anxiety / Depression
❒	Heart disease	❒	Asthma, Bronchitis, Emphysema
❒	Stroke	❒	Muscular disorder
❒	Ulcerative colitis or Crohn's disease	❒	Autoimmune disease
❒	Anemia	❒	Seizures
❒	Jaundice	❒	Bladder / Kidney
❒	Addictions / Alcohol	❒	Thyroid disease
❒	HIV / AIDS	❒	Genetic conditions

Other: _____

_____

Major Surgeries or Recent Hospitalizations	Where	Year

Relatives with History of Cancer	Cancer type	Age at diagnosis

Patient Name: _____

Social History

Current or Prior Occupation? _____

Exposure to hazardous chemicals? ❒ No ❒ Yes, Chemicals _____

Do you drink alcohol? ❒ No ❒ Yes, Drinks per day _____

Ever used any tobacco products? ❒ No ❒ Yes, What kind _____

Cigarettes per day? _____ What age begin? _____ What age stop? _____

Highest level of education achieved _____

Preferred language (verbal and written) _____

Do you currently have any major symptoms (circle all that apply):

Fever, chills, weight loss, fatigue

Headaches, numbness, seizures

Visual changes, double vision, ear pain, ringing

Hoarseness, difficulty swallowing

Swollen lymph nodes, masses

Chest pain, shortness of breath, cough

Heartburn, nausea, diarrhea, bloody stools, hemorrhoids

Urinary frequency, burning, bleeding

Leg swelling, worsening muscle weakness

Any Other Symptoms _____

Are you in any Pain? ❒ No ❒ Yes, Scale of 1-10? _____

What medications are you taking for pain? _____

Please include any other information that you think is important that we know.

_____

_____