Tammy Walker Cancer Center
Salina Regional Health Center

511 South Santa Fe,
Salina, Kansas 67401
Radiation Oncology: 785-452-4820
Medical Oncology: 785-452-4860

FEMALE PATIENT HISTORY FORM

BASIC DATA:

Name: _____ Age: _____ Date of Birth: ___/___/_____
Address: _____ City: _____ Zip Code: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____
Voicemail? YES [__] NO [__] Best Number to be Reached at: Home YES [__] Cell [__]
E-Mail: _____ Social Security Number: _____
Person we could contact if we are unable to reach you:
Name: _____ Phone: (_____) _____ Relationship: _____

PHYSICIAN INFORMATION:

REFERRING PHYSICIAN	ADDRESS	PHONE NUMBER

PRIMARY PHYSICIAN	ADDRESS	PHONE NUMBER

OTHER PHYSICIAN(S)	ADDRESS	PHONE NUMBER

DENTIST	ADDRESS	PHONE NUMBER

EYE DOCTOR	ADDRESS	PHONE NUMBER

PREFERRED PHARMACY	ADDRESS	PHONE NUMBER

MEDICAL HISTORY:

Give a brief explanation of why you were referred to us: (Include area that needs to be treated, symptoms, etc.)

_____

_____

What kind of diagnostic tests have you done to this point to diagnose your condition? (CT scans, MRI, PET scan, biopsy, blood tests)?

DATE	DIAGNOSTIC TEST	LOCATION

	YES	NO
Do you have any metal in your body?		
Have you had cancer previously? If Yes, where? when?		
Have you had radiation or cobalt treatments? If yes, where? when? Body part treated? Who was the physician?		
Have you had chemotherapy previously? If Yes, where? when? Drugs? Who was the physician?		

List all surgeries done, including any done as a child (tonsillectomy, appendectomy, gallbladder, hysterectomy):

DATE	SURGERY	PHYSICIAN

List hospitalizations other than surgeries:

DATE	REASON HOSPITALIZED

Past injuries (bone fractures, falls, car accidents, etc.):

DATE	INJURY

List all medications you are currently taking (includes over-the-counter medications, ointments, medicated patches, creams, inhaled medications, drops, injections, birth control pills, vitamins and herbs, etc.):

MEDICATION	DOSAGE	TIMES TAKEN DAILY	REASON TAKEN

FAMILY HISTORY:

Do you think your cancer is hereditary? YES [__] NO [__]

	LIVING (L) DECEASED (D)	AGE NOW AGE AT DEATH	CURRENT HEALTH STATUS CAUSE OF DEATH	EVER HAD CANCER?		CANCER SITE
FATHER				YES	NO	
MOTHER				YES	NO	

BROTHER (B) SISTER (S)	LIVING (L) DECEASED (D)	AGE NOW AGE AT DEATH	CURRENT HEALTH STATUS CAUSE OF DEATH	EVER HAD CANCER?		CANCER SITE
				YES	NO	
				YES	NO	
				YES	NO	
				YES	NO	
				YES	NO	
				YES	NO	
				YES	NO	
SON (S) DAUGHTER (D)	**LIVING (L) DECEASED (D)**	**AGE NOW AGE AT DEATH**	**CURRENT HEALTH STATUS CAUSE OF DEATH**	**EVER HAD CANCER?**		**CANCER SITE**
				YES	NO	

				YES	NO	
				YES	NO	
				YES	NO	
				YES	NO	

SOCIAL HISTORY:

Employer: _____ Phone: (_____) _____

If retired, previous occupation? _____

How far did you go in school? _____

Have you traveled overseas? YES [__] NO [__] If yes, where have you traveled? _____

Marital status: Single [__] Married [__] Divorced [__] Widowed [__]

Birthplace: _____

Spouse or significant other's name: _____

Spouse's employer: _____ Phone: (_____) _____

Are your spouse and/or children supportive during this time? YES [__] NO [__]

Do you have stress at home or on the job? YES [__] NO [__] Explain: _____

Have you ever smoked cigarettes, pipes, etc? YES [__] NO [__]

If yes, number of pack(s) per day? _____ for _____ years

Have you quit smoking? YES [__] NO [__] When? _____

Have you ever chewed tobacco? YES [__] NO [__] How much? _____

Have you quit? YES [__] NO [__] When? _____

Do you drink alcohol? YES [__] NO [__] Type? _____

How many drinks per day? _____ per week? _____ per month? _____

If you have a history of excessive drinking, when did you quit? _____

Do you drink caffeine? coffee YES [__] NO [__] tea YES [__] NO [__] soda pop YES [__] NO [__]

Cups per day? _____ Cups per week? _____

Have you ever used recreational drugs? YES [__] NO [__]

If yes, what kind and when? _____

Have you ever served in the military? YES [__] NO [__] When? _____

Have you been exposed to asbestos? YES [__] NO [__] toxic chemicals YES [__] NO [__] dust YES [__] NO [__]

If yes, what kind and when? _____

Do you have a routine exercise program? YES [__] NO [__]

In a typical 24 hour period, how many hours do you spend in bed? _____

Do you see a doctor regularly for any medical conditions? YES [__] NO [__]

If yes, please describe: _____

Who do you live with? _____

Are they able to help you? YES [__] NO [__]

Are you able to perform your activities of daily living? YES [__] NO [__]

Do you/your family feel your physical or mental abilities are diminished? YES [__] NO [__]

Do you have a Living Will? YES [__] NO [__]

Do you have a Durable Power of Attorney (DPOA)? YES [__] NO [__]

If yes, what is the DPOA's name and phone? _____

Is there anything you would like to discuss with the doctor/nurse in private? YES [__] NO [__]

REVIEW OF SYSTEMS: Do you currently have or ever had?

	YES	NO	COMMENT
GENERAL:			
Weight changes			
Chills/shakes			
Weakness/malaise			
Lethargy			
Fever			
Fatigue			
Appetite changes			Increase [__] Decrease [__]
What is your usual weight? _____ lbs.			
Been on a diet in the past year			
Any pain now Where? _____ Rate: (0 as none through 10 as worst) _____			
Headaches			
Please rate your physical ability using this Karnofsky scale: 20% Very sick, hospitalized, active support needed 30% Severely disabled, needs hospitalization, death not imminent 40% Disabled, needs special care and assistance 50% Requires frequent medical help and considerable assistance 60% Able to care for most needs, requires occasional help 70% Unable to do active week, but able to care for self 80% Normal activity, but requires effort 90% Normal, only minor signs and symptoms 100% Normal, no complaints			
ALLERGIC/IMMUNOLOGIC:			
Allergies to medications			
If so, please list medication AND reaction:			
Reaction to IV dye from a radiology test			
Did you have childhood immunizations Varicella (chicken pox) YES [__] NO [__] shingles YES [__] NO [__]			
Have you had a recent flu vaccine			When?
Have you been vaccinated for pneumonia			When?
Have you been tested for HIV in the past			Results?
Do you want to be tested for HIV			
Any other allergies			Describe:
HEAD			
Hair loss			
EYES			
Blurred vision			
Double vision			
Tearing			

	YES	NO	COMMENT
Sensitivity to light			
Visual difficulties			
Glasses YES [__] NO [__] contact lenses YES [__] NO [__]			
Lost or had a change in vision			
Attacks of blindness			
Pain or redness in your eyes			
Swelling of your face or eyes			
Glaucoma YES [__] NO [__] Cataracts YES [__] NO [__]			
When was your last eye exam? _____			
Lens implants			
EARS, NOSE, MOUTH AND THROAT			
Trouble swallowing			
Ear pain			
Nose bleeds			
Sore throat			
Decreased hearing			
Mouth dryness			
Oral bleeding			
Sinus problems			
Sputum production			
Pain in stomach			
Altered taste			
Ringing in ears			
Trouble opening your mouth			
Feel as if things are spinning around			
Wear hearing aids			If yes, right ___, left ___ or both ___
Ear implants			If yes, right ___, left ___ or both ___
Troubled with hoarseness			
Voice changes			
Bleeding gums			
Sore tongue			
Do you wear dentures?			Full ___ Partial ___
When was your last visit to the dentist? _____			
NECK			
Masses/lumps			
Muscle weakness			
Pain			
Trouble with range of motion			
Swelling			
SKIN			
Bruising			
Dry skin			
Change in nails			
Sensitivity to sunlight			
Itchiness			
Rashes			
Do you use tanning beds?			
Lumps in your skin or moles			Where?

	YES	NO	COMMENT
Abnormal lesions on your skin			Where?
Great deal of sun exposure			
Skin cancer If yes, how was it treated? _____			
Do you wear a hat?			
BREASTS			
Breast masses			Where?
Nipple discharge			
Nipple inversion			
Pain			
Have you noticed any changes of your breasts, like: Skin changes Redness Warmth Axillary nodes			
Did you breast feed your children?			How often?
Have you ever had a biopsy or surgery on your breast?			Where? When?
When was your last mammogram? _____ Where done? _____			
If you were born before 1972, did you have exposure to DES from maternal use during pregnancy?			
CARDIOVASCULAR			
Irregular heart beat			
Chest pain			
Difficulty breathing			
Any swelling			
Difficulty breathing while lying down			
Pounding or racing of your heart			
Heart disease			
High [__] or low [__] blood pressure			
Pacemaker If yes, it is VERY important to receive a copy of your card!			
Bypass surgery			
Angioplasty (balloon surgery)			
Coronary artery stents			
RESPIRATORY			
Cough			
Shortness of breath			
Coughing up blood			
Hiccups			
Chest pain			
Wheezing			
Cough up any sputum			
Difficulty breathing while lying down			
Pneumonia			
Tuberculosis			

	YES	NO	COMMENT
Bronchitis			
Asthma			
Emphysema			
Oxygen at home			
When was your last chest x-ray or CAT scan? _____			
GASTROINTESTINAL			
Abdominal pain			
Changes in bowel habits			
Constipation			
Diarrhea			
Heartburn			
Vomiting blood			
Blood in your stools			
Hemorrhoids			
Black, tarry stools			
Nausea			
Pain or cramping in stomach			
Appetite changes			
Vomiting			
Stomach ulcers			
Trouble swallowing			
Food stuck after you have tried to swallow it			
Choke with foods or liquids			
Liver disease			
Jaundice			
Hepatitis			
Have you had a colonoscopy?			When? Where?
In the last year, have your bowel habits changed			Describe:
GENITOURINARY/GYNECOLOGICAL/SEXUAL			
Pain with urination			
Frequency of urination			
Genital warts			
Blood in your urine			
Lose control of your urine			
Get up at night to urinate? If yes, how many times? _____			
Kidney stones			
Bladder stones			
Urgency with urination			
Vaginal discharge			
Vaginal spotting			
Urine stream smaller than before			
Capacity to hold urine diminished			
Bladder infection			
Kidney infection			
FEMALE ONLY			

	YES	NO	COMMENT
Possibility of pregnancy at this time			
Age at your first pregnancy: _____ Number of pregnancies: _____ Number of deliveries: _____ Number of miscarriages: _____ Number of living children: _____ Number of deceased children: _____			
Complications with your pregnancies			If yes, explain:
Do you use birth control of any kind			Kind? For how long?
Age you started menstruation: _____			
Do you still menstruate			
Date of last menstruation: _____			
Do you bleed between periods			
Age at menopause: _____			
Postmenopausal bleeding or discharge			Type: For how long:
When was your last pap smear: _____ Name of doctor: _____ Result: _____			
Your sexual experiences have been with: Women [__] Men [__] Both women and men [__]			
Are you sexually active			
Your sexual ability the same as several years ago			
Any problems regarding sexuality			
Ever had bleeding with intercourse			
Ever had pain with intercourse			
Vaginal itching			
Ever had a sexually transmitted disease			If yes, what type of treatment:
Number of sexual partners: _____			
MUSCULOSKELETAL			
Arthritis			
Bone pain			
Muscle weakness			
Problems with range of motion			
Broken any bones			
Pain in legs with walking or standing			
Pain or swelling in arms, hands, legs or feet			
Pain or swelling in joints			
Stiffness or limitation of movement			
Trouble with neck or back			If pain, where located:
Diagnosis of osteoporosis			Bone density scan:
Do you use a chiropractor			Name:
NEUROLOGICAL			
Disorientation			
Dizziness			

	YES	NO	COMMENT
Changes in walking			
Headaches			
Memory loss			
Any areas with tingling or burning pain			
Paralysis			
Seizures			
Sensory changes in hearing, sight, touch, taste or smell			
Stroke			
Any areas that feel numb			
Problems speaking or writing			
Personality changes			
Fall easily			
Changes in the coordination of your arms or legs			
Aneurysm clips in your brain			
Neurostimulators			
PSYCHIATRIC			
Hallucinations/delusions			
Depression			
Mood swings			
Nervousness			
Tension or stress			
Problems with your memory			
Ever had a nervous breakdown			
See a psychiatrist			
Take psychiatric drugs			
Claustrophobia			
ENDOCRINE			
Diabetes			
Do you take metformin (Glucophage)			
Hot flashes			
Menstrual irregularities			
Thyroid disease			
Changes in your tolerance to heat or cold			
Night sweats			
Excessive thirst or hunger			
More or less body hair than usual			
HEMATOLOGIC/LYMPHATIC			
Bruising easily			
Enlarged lymph nodes			
Anemia			
Blood transfusion			If yes, any adverse reaction? Explain:

Patient's Signature: _____ Date: ___/___/_____

Name of person completing this form if other than patient:

Name: _____ Relationship: _____

Spouse/Significant other's signature and why you are signing for patient:

Signature: _____Why signing: _____ Date: ___/___/_____

Nurse's Signature: _____ Date Reviewed: ___/___/_____

Physician's Signature: _____ Date Reviewed: ___/___/_____