Lake Health / University Hospitals
Seidman Cancer Center
A joint venture of Lake Health and University Hospitals
9485 Mentor Ave, Suite 3
Mentor, Ohio 44060
(440) 205-5755

Place patient sticker here

New Patient Health History Form

Date: _____

Last name: _____ First name: _____ Date of birth: _____

Person completing this form: ☐ Patient ☐ Other (relationship): _____

Why have you come to the Cancer Center today?

☐ Initial consultation ☐ Second opinion ☐ Transferring care ☐ Other: _____

Who referred you here? _____

Who is your family doctor? _____ Phone: _____

Please list any other doctors you see:

_____ Phone: _____

_____ Phone: _____

What is your medical reason for coming to the Cancer Center?

_____

_____

Personal History: Check all previous illnesses or conditions below.

☐ Diabetes (high blood sugar)	☐ Lung problems	☐ High blood pressure
☐ Kidney problems	☐ Heart	☐ Arthritis
☐ Stroke	☐ Glaucoma/eye problems	☐ Bleeding disorder
☐ Hearing problems	☐ Bowel/intestinal problems	☐ Seizures
☐ Stomach problems	☐ Thyroid disease	☐ Mental health problems
☐ Skin problems	☐ Liver disease	

☐ Other health problems: _____

Past surgeries (Include type of surgery and date):

_____

_____

Prior cancers (before current illness) ☐ No ☐ Yes

Prior radiation treatment ☐ No ☐ Yes

Prior chemotherapy ☐ No ☐ Yes

Do you have an Advance Directive and/or Living Will? ☐ No ☐ Yes

(If No) Would you be interested in information on Advance Directive/Living Will? ☐ No ☐ Yes

Patient, do not write in the space below (for clinical team notes)

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Preferred pharmacy: _____

Address: _____

Phone: _____

Please list any medications and supplements that you take on a daily or frequent basis.

Include prescription and over-the-counter medications, vitamins, minerals, and herbs.

Medications	Dose/how often	What is it for?

Are you allergic to anything? ☐ Yes ☐ No

List all allergies and describe your reaction:

_____

_____

_____

Please list any blood relatives who have had cancer. For female relatives give their maiden name in parentheses. Under the section "relationship to you" give the type of relation (1st cousin, 2nd cousin, grandparent, etc.) and indicate whether this relative was on your mother or father's side of the family. If you are adopted, but know about your birth parents and family, please give that information.

Initials & Gender (F/M)	Relationship to you (Indicate maternal/paternal)	Type of cancer & relative age at diagnosis (if deceased, age at death)

Would you like a referral to the Center for Human Genetics at University Hospitals of Cleveland, which offers programs designed to help people with a family history of cancer? ☐ Yes ☐ No

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Spiritual practice/religious tradition: _____

Occupation: _____ Currently working? ☐ Yes ☐ No

Usual industry/usual occupation (what do you do at work): _____

Retired? ☐ Yes ☐ No Medical leave? ☐ Yes ☐ No On disability? ☐ Yes ☐ No

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Main support person: _____

Relationship: _____ Phone: _____

Who takes care of you when you are ill? _____

Do you live in: ☐ House ☐ Apartment ☐ Extended care facility ☐ Other

Do you live: ☐ Alone ☐ With family/friends

Are there times when you feel unsafe around people you know or live with? ☐ Yes ☐ No

_____

What is the highest level of education you completed?

☐ Grade: _____ ☐ High School ☐ 2-year degree ☐ 4-year degree ☐ Graduate degree

How do you like to learn?

☐ Reading ☐ Listening ☐ Practicing ☐ Memorizing ☐ Demonstration

☐ Other: _____

Have you ever used tobacco products? ☐ Yes ☐ No

If yes, what type:
☐ Cigarettes _____ # of packs/day _____ # of year
☐ Cigars _____ # of packs/day _____ # of year
☐ Chewing tobacco _____ # of packs/day _____ # of year

Have you quit? ☐ Yes ☐ No If yes, when? _____

Do you drink alcohol? (including beer and wine) ☐ Yes ☐ No If yes, how much? _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, what do you use? _____

Are you currently having pain? ☐ Yes ☐ No If yes, where is the pain? _____

Circle the number that best describes your pain:

No pain (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Worse possible pain

If having pain, what makes it better and/or worse? _____

Height: ____ Weight: ____ What did you weigh one year ago? ____ Six months ago? ____ One month ago? ____

Diet: ☐ Regular ☐ Diabetic ☐ Low salt ☐ Low fat ☐ Low cholesterol ☐ Vegetarian

☐ Other: _____

Compared to normal, I would rate my food intake during the past month as:

☐ Unchanged ☐ More than usual ☐ Less than usual

I am now eating: ☐ Regular food ☐ Soft food ☐ Liquid supplements ☐ Only liquids

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GENERAL
- ☐ None
- ☐ Fever-chills
- ☐ Sweats
- ☐ Change in sleep habits
- ☐ Fatigue
- ☐ Other: _____

SKIN
- ☐ None
- ☐ Open sores
- ☐ Change in moles
- ☐ Abnormal color
- ☐ Rashes
- ☐ Other: _____

HEAD & NECK
- ☐ None
- ☐ Nose bleeds
- ☐ Sores in mouth or throat
- ☐ Sore throat
- ☐ Other _____

Last dentist visit: _____

UNIARY
- ☐ None
- ☐ Burning
- ☐ Frequency
- ☐ Blood in urine
- ☐ Dribbling
- ☐ Unable to control bladder
- ☐ Other: _____

ENDOCRINE
- ☐ None
- ☐ Cold intolerance
- ☐ Hot flashes
- ☐ Other: _____

NEUROLOGICAL
- ☐ None
- ☐ Memory changes
- ☐ Numbness/tingling
- ☐ Dizziness/fainting
- ☐ Weakness
- ☐ Blurred vision
- ☐ Headache
- ☐ Hearing difficulty
- ☐ Ringing in ears
- ☐ Seizures
- ☐ Unbalanced walking
- ☐ Other: _____

HEART
- ☐ None
- ☐ Leg/pain/swelling
- ☐ Chest pain
- ☐ Fast heart beat
- ☐ Other: _____

MUSCULOSKELATAL
- ☐ None
- ☐ Joint swelling
- ☐ Joint/back pain
- ☐ Stiffness
- ☐ Trauma
- ☐ Falls
- ☐ Other: _____

MALE ONLY
- ☐ None
- ☐ Problems passing urine
- ☐ Enlarged prostate
- ☐ Other: _____

Date of last prostate exam: _____

GASTROINTESTINAL AND NUTRITION
- ☐ None
- ☐ Yellow skin or eyes
- ☐ Cramping/stomach pain
- ☐ Nausea/vomiting
- ☐ Problems swallowing
- ☐ Indigestion/heartburn
- ☐ Reflux
- ☐ Blood in stools
- ☐ Black stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Other: _____

LUNGS
- ☐ None
- ☐ Wheezing
- ☐ Cough
- ☐ Short of breath
- ☐ Bloody phlegm/sputum
- ☐ Other: _____

HEMATOLOGY
- ☐ None
- ☐ Abnormal bleeding
- ☐ Prior transfusion
- ☐ Easy bruising
- ☐ Swelling in groin/armpit/neck
- ☐ Other: _____

BREAST
- ☐ None
- ☐ Changes
- ☐ Lumps
- ☐ Nipple discharge
- ☐ Other: _____

Date of last mammogram: _____

FEMALE ONLY
- ☐ Unusual bleeding
- ☐ Other: _____

Date of last menstrual period: _____

Date of last pap smear: _____

Number of pregnancies: _____

Age at 1st pregnancy: _____

Pregnant ☐ Yes ☐ No Birth control ☐ Yes ☐ No Hormone replacement ☐ Yes ☐ No

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ACTIVITY:

Over the past month, I would rate my activity as:

☐ Normal, with no limitations

☐ Not my normal self, but able to be doing fairly normal activities

☐ Not feeling up to most things, in bed or chair less than half the day

☐ Rarely out of bed or chair

Do you need help with:

☐ Bathing ☐ Walking ☐ Stairs ☐ Preparing meals ☐ Other: _____

Home health care used:

☐ None ☐ Lake Health Home Care ☐ University Home Care ☐ VNA ☐ Other _____

Community agencies used:

☐ None ☐ Support Group ☐ Meals on Wheels ☐ Other _____

COPING:

It is normal to feel some distress during times of illness. Please circle the number that best describes your level of distress on the average, (over the past week):

No distress (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Most severe distress

Check the factors that you feel contribute to your distress:

Practical

☐ Housing

☐ Insurance

☐ Work/school

Physical

☐ Pain

☐ Nausea

☐ Fatigue

☐ Sleep problems

☐ Getting around

Communication

☐ Communication with partner

☐ Communication with children

☐ Communication with doctor

Emotional

☐ Worry

☐ Sadness

☐ Depression

☐ Nervousness

☐ Hopelessness

Spiritual/Religious Concerns

☐ Related to God

☐ Loss of faith

Over the past 2 weeks have you had thoughts of hurting yourself in some way? ☐ Yes ☐ No

Would you like more information about a support group? ☐ Yes ☐ No

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What is your main concern regarding your illness and treatment?

What else would you like us to know about you?

What questions may we answer for you?

Thank you for completing this form. Please bring it with you to your doctor's appointment.

Patient's signature _____ Date _____

Do not write below line, for staff use only

Reviewed by _____ Date _____

Referral made to Social Worker _____ ☐ Yes ☐ No Date _____
(If referral made, please make copy for SW)

Patient's Family Cancer History

Please fill out this form to indicate any **blood** relatives who have had **cancer**.
If you are adopted, but know your birth family history, please give that information.

○	**No Family History of Cancer**
○	**No Family History of Blood Disorders**
○	**UNKNOWN Family History**

	Alive & Well	Alive, history of Illness	Alive, currently Ill	Cancer Type/ Blood Disorder	Age at Diagnosis	Deceased	Age at Death
Father	○	○	○			○	
Mother	○	○	○			○	
Brother #1	○	○	○			○	
Brother #2	○	○	○			○	
Brother #3	○	○	○			○	
Sister #1	○	○	○			○	
Sister #2	○	○	○			○	
Sister #3	○	○	○			○	
Other Sibling	○	○	○			○	
Other Sibling	○	○	○			○	
Child #1	○	○	○			○	
Child #2	○	○	○			○	
Child #3	○	○	○			○	
Maternal Relatives:							
Grandmother	○	○	○			○	
Grandfather	○	○	○			○	
Aunt #1	○	○	○			○	
Aunt #2	○	○	○			○	
Uncle #1	○	○	○			○	
Uncle #2	○	○	○			○	
Cousin	○	○	○			○	
Other Relative:	○	○	○			○	
Paternal Relatives:							
Grandmother	○	○	○			○	
Grandfather	○	○	○			○	
Aunt #1	○	○	○			○	
Aunt #2	○	○	○			○	
Uncle #1	○	○	○			○	
Uncle #2	○	○	○			○	
Cousin	○	○	○			○	
Other Relative:	○	○	○			○	

Patient Signature Date Completed