St. Charles
CANCER CENTER

Patient Label

PATIENT MEDICAL INFORMATION AND CARE PLANNING TOOL

Patient Name:_____ **Date:**_____

Age: _____ Date of Birth: _____ What name do you prefer we call you? _____

Address:_____City:_____State:_____Zip:_____

Phone:_____Cell Phone_____

Referring Doctor:_____Primary Care Doctor:_____

Other doctors to receive copies of records : _____

Primary insurance: _____

Primary ID number**:** _____Group name _____Group number_____

Secondary insurance: _____

Secondary ID number**:**_____ Group name_____ Group number_____

CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS **(Describe why you have been referred here):**

SYMPTOM REVIEW **(Circle symptoms that apply)**:

GENERAL
Fevers
Night Sweats
Weight Loss
Fatigue
Pain

HEAD/NECK
Mouth Sores
Hoarse Voice
Poor Taste

PSYCHOLOGIC
Worried / Anxious
Sad / Depressed
Insomnia

G I
Nausea
Diarrhea
Constipation
Abdominal Pain
Blood in Stools
Problems Swallowing
Heartburn
Reflux
Jaundice
Cirrhosis

CARDIOVASCULAR
Chest Pain / Angina
Irregular Beats
Racing / Fluttering
Murmur
Leg Swelling

RESPIRATORY
Short of Breath
Cough
Coughing Blood
Snoring

INFECTIOUS
HIV Risk / Exposure
TB Exposure
Hepatitis Exposure
Frequent Infections
Recent Antibiotics

ENDOCRINE
Thin Bones
Hot Flashes
Thyroid Problems

HEMATOLOGY
Blood Clots:
DVT or PE
Abnormal bleeding
Big Lymph Glands
Anemia
Blood Disorder

URINARY
Burning / Pain
Blood in Urine
Kidney Stones
Frequent at Night
Dribbling
Incontinence

NEUROLOGIC
Headaches
Vision Changes
Numbness / Tingling
Weakness
Memory Changes
Hearing Problems
Seizures

BONE / JOINTS
Bone Pain
Muscle Pain
Back Pain
Arthritis

IMMUNE
Scleroderma
Dermatomyositis
Inflammatory Bowel Disease
Crohn's Disease
Ulcerative Colitis

MALE
Erectile Dysfunction
Enlarged Prostate

FEMALE
Breast Lumps
Vaginal Bleeding / Spotting

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FEMALE PATIENTS ONLY

Age of onset of first menstrual period: _____Pregnancies (#) _____ Miscarriages (#) _____
Age at first live birth _____ Did you breast feed? □Yes □No Total # of month's breast fed _____
Years on birth control pills (#) _____ Years on hormone replacement therapy (#) _____
Last menstrual period (date) _____
Date of your last mammogram _____ Date of last Pap smear _____

FEMALE PATIENTS AGE 13-54 ONLY. Please complete this section and sign.
Please select from the following choices your method of birth control:

☐ Hysterectomy ☐ Depo Provera (injection within past 90 days) ☐ Abstinence ☐ IUD
☐ Tubal ligation ☐ Partner had vasectomy ☐ Birth control pills
☐ Norplant ☐ Menopause ☐ Condoms plus foam
☐ Other (please explain): _____

If this status changes, I will inform my doctor, nurse, or therapist.
SIGNATURE:_____

FUNCTIONAL STATUS (Please circle the most appropriate number)

0 Fully active; no performance restrictions.
1 Strenuous physical activity restricted but walking and able to do light work.
2 Can care for self but unable to carry out any work; up > 50% of waking hours.
3 Capable of only limited self care; confined to bed or chair > 50% of waking hours.
4 Completely disabled; cannot carry out any self care; totally confined to bed or chair.

NUTRITION PROBLEMS?
(Please circle)
Feel full quickly
Taste changes
Problems chewing
Problems swallowing

DO YOU HAVE ANY OF THE FOLLOWING?
(Please circle)
Pacemaker
Ports
Implanted devices
Catheter

PAST MEDICAL HISTORY:

Past illnesses and chronic medical problems (year and type): _____
_____
_____
_____

Past operations (year and type): _____
_____
_____
_____

Past serious injuries (year and type): _____
_____
_____
_____

Other hospitalizations (name and location of hospital, date and reason): _____
_____
_____

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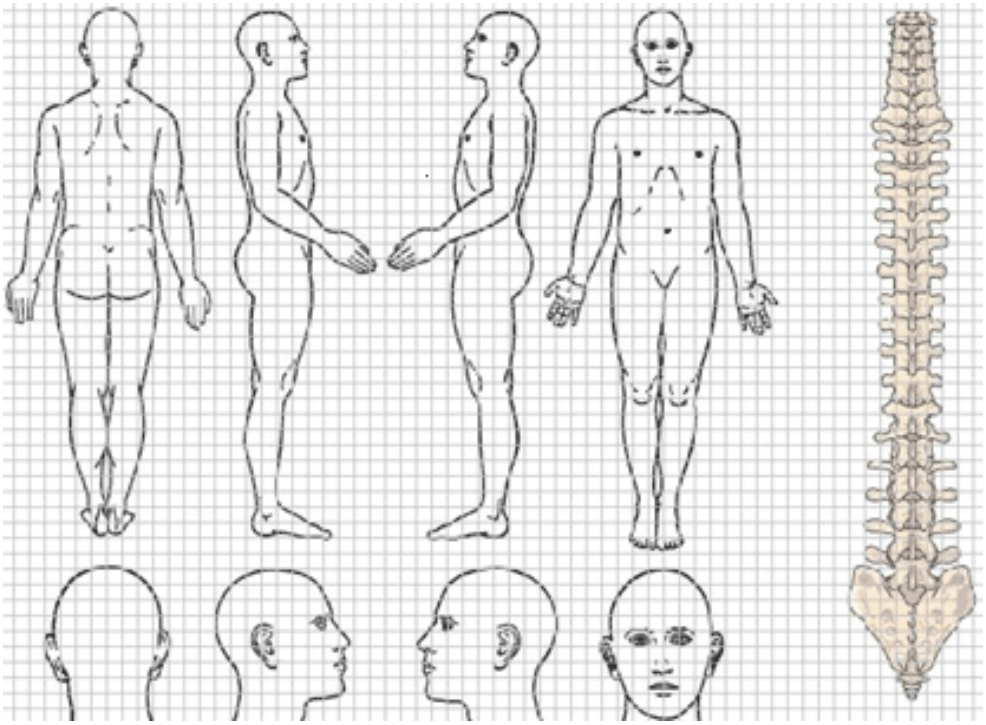
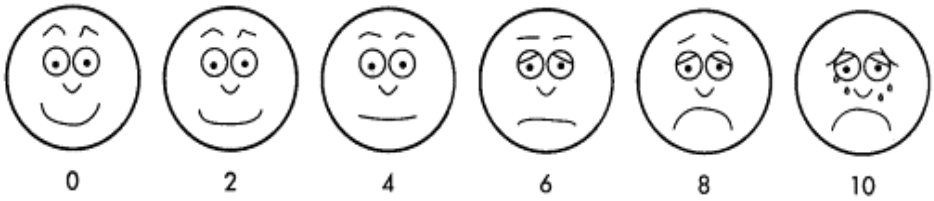
PAIN ASSESSMENT

Mark all your areas of pain with an "X"





How would you rate your pain using the pain scale 0-10 above?

Area	____	Area	____	Area	____	Area	____
At present	____	At present	____	At present	____	At present	____
At worst	____	At worst	____	At worst	____	At worst	____
At best	____	At best	____	At best	____	At best	____
Area	____	Area	____	Area	____	Area	____
At present	____	At present	____	At present	____	At present	____
At worst	____	At worst	____	At worst	____	At worst	____
At best	____	At best	____	At best	____	At best	____

Pain medication used:

Short acting Medication _____ How many in the past 24 hours _____

Long acting Medication _____

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Have you ever had any **X-ray treatments** (including treatment for birthmarks, acne, etc.), radiation, cobalt or chemotherapy treatments?
☐ No ☐ Yes If Yes, describe: _____
_____

PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBS you are now taking:

Drug Name	Dose	Frequency	For What?

ALLERGIES TO MEDICATIONS:

Name	What happens to you when you take it?

COMPLEMENTARY AND ALTERNATIVE MEDICINE QUESTIONNAIRE

Are you presently using any of these therapies? Please check all that apply:

✓	Item	✓	Item
	Meditation		Acupuncture
	Relaxation		Hypnosis
	Biofeedback		Cognitive-behavioral therapy
	Yoga		Guided imagery
	Massage		Tai Chi
	Reiki		Therapeutic touch
	Qigong		Pulsed fields
	Magnetic fields		Alternating or direct-current fields
	Other modalities (please specify): _____		
	_____		

Have you any interest in a referral for any of the above modalities (please specify): _____
_____

Dietary Supplements: (please list): _____
_____

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SOCIAL/OCCUPATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Significant Other

Occupation:_____

If retired, former occupation:_____

Employer: _____

Spouse's or Significant Other's Name and Occupation:_____

Number and ages of children: _____ at home _____

Other residents:_____

List your support system (friends, church, and other organizations): _____

_____

Education (Circle Highest) 1 2 3 4 5 6 7 8 Elementary 1 2 3 4 High School 1 2 3 4 College Over 4

Birth Place:_____

City State Country_____

Place where raised _____ Military Service _____

Please describe interests or hobbies you pursue with any regularity: _____

_____

_____

Have you experienced any major life changes in the last few years? (e.g. moving, change of job, loss of close relative or friend) Please describe: _____

_____

HABITS

Have you used:

Cigarettes?	☐ No	☐ Yes	How many per day? _____ For how many years?
Have you quit?	☐ No	☐ Yes	If yes, when?
Cigars?	☐ No	☐ Yes	How many per day? _____ For how many years?
Have you quit?	☐ No	☐ Yes	If yes, when?
Pipes?	☐ No	☐ Yes	How many per day? _____ For how many years?
Have you quit?	☐ No	☐ Yes	If yes, when?
Chew/Dip?	☐ No	☐ Yes	How many per day? _____ For how many years?
Have you quit?	☐ No	☐ Yes	If yes, when?

Would you like help for yourself, or your family, to quit tobacco? ☐Yes ☐ No

Do you drink alcoholic beverages? ☐ No ☐ Yes

How many drinks per day? _____

Have you ever used marijuana? ☐ No ☐ Yes

Have you ever used street drugs? ☐ No ☐ Yes

Have you had any occupational/unusual exposure to asbestos or toxic chemicals? ☐ No ☐ Yes

If yes, describe: _____

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FAMILY HISTORY OF CANCER DIAGNOSIS

Relation	Age	Location / Type of Cancer

SOCIAL SERVICE

We provide social services for our patients and family members. Do you feel that you may need information and / or assistance in any of the following areas?

Yes	No	Item
		Information for reduced cost medications
		Finances
		Transportation
		Temporary Housing / Lodging
		Support groups
		Ethnic / Cultural / Spiritual issues
		Written / Verbal Communication
		Counseling for yourself and / or family members (including sexual, marital, substance abuse concerns)
		Home health services or help at home
		Hospice services

Do you have Internet access: ☐ Yes ☐ No
Would you like to receive information on support services and upcoming events via e-mail?
E-mail address

Yes	No	Question
		Are you currently in a situation where you feel unsafe?
		Are you currently in a relationship where you are physically hurt, threatened, or made to feel afraid?
		I find it difficult to make decisions.
		I feel downhearted, blue and sad.
		I am more irritable than usual.
		Do you need help preparing meals?

Yes	No	Question
		I am feeling lonely.
		I often feel fearful.
		I notice that I am losing weight.
		I am restless and can't keep still.
		I have crying spells, or feel like it.
		I worry about the future.
		I do not feel that I am useful and needed.
		Do you need help with grocery shopping?

National Comprehensive Cancer Network®

NCCN Guidelines™ Version 1.2011
Distress Management

NCCN Guidelines Index
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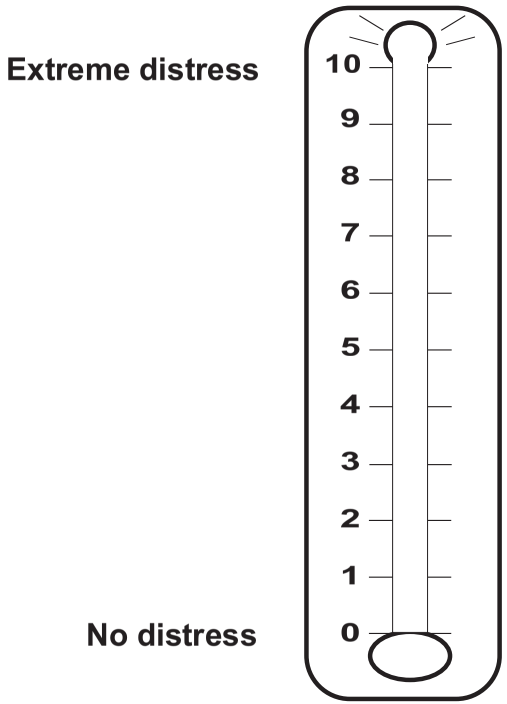
Discussion

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions

YES	NO	Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues

YES	NO	Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	Spiritual/religious concerns

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Tingling in hands/feet

Other Problems: _____

_____