

Cancer Center of North Dakota
Oncology Patient Information

Patient Name: _____ Date of Visit: _____
Date of Birth: _____ Age: _____ Social Security No. _____
Phone: Home: _____ Work _____ Cell _____
Address: _____ City: _____ State _____ Zip _____
Personal Physician _____ Referring Physician _____
Reason for visit _____

Pharmacy _____
Do you need an interpreter? Yes No Language: _____

PAST MEDICAL HISTORY

Drug Allergies: Yes No
If "Yes", please list: _____
Type of reaction? Rash, hives, fainting, nausea, intolerance, other: _____
Other: Hay Fever :Y N Food: Y N Latex: Y N Environmental: Y N Xray dye: Y N
List all Medications you are taking, including Prescriptions, Over the Counter, & Herbal
(Name, Dose, Frequency):

Have you had:
 Mumps Measles Chicken Pox German Measles Mononucleosis
Have you had the following Immunizations: Influenza (flu) Hepatitis
 Pneumococcal (pneumonia) DTC (tetanus) other _____

Have you had a T.B. Test: Y N Date: _____ Positive Negative (circle one)

What Surgeries have you had and when?

Other Hospitalizations: _____

Have you previously received Chemotherapy: Y N
When _____ Why _____ Where _____

Have you previously received Radiation Therapy: Y N
When _____ Why _____ Where _____

Do you use tobacco now? Y N What type? Cigarette, Pipe, Cigar, Smokeless
If yes, how much per day? _____ How many years? _____

Have you ever used tobacco in the past? Y N When did you quit? _____

Have you experienced/experience now, second hand smoke? Y N
When _____

Do you drink alcohol? Y N if yes, how much, type and how often? _____

FAMILY HISTORY

	Living	Deceased	Cancer	Other Conditions
Mother				
Father				
Sisters				
Brothers				
Children				
Children				

SOCIAL HISTORY

Single Married Divorced Separated Widowed

Spouse's Name: _____ Home Phone: _____

Spouse's Employer: _____ Work Phone: _____

Number of Children _____ Relationships: Good Poor

Are you presently employed? Y N Where? _____

Address: _____ Job Title _____

Are you retired? Y N What was your job title? _____

Military Service? Y N If yes, where? _____ When? _____

Other than your spouse, who should we contact in case of an emergency?

Name: _____ Relationship _____ Phone: _____

Do you take care of anyone? Y N Will you have help at home after treatments? Y N

Service: Home Health Hospice Meals on Wheels Housekeeper
 Private attendant Nursing/Rehab/Aide/Social Worker

Where do you live? Apartment/House Skilled Nursing Facility
 Shelter Home Assisted Living Facility Homeless

REVIEW OF SYMPTOMS

GENERAL

Have you lost any weight in the last 6 months? Y N How Much _____ Usual Weight _____

Have you had any night sweats? Y N

Have you had severe itching? Y N

Have you been exposed to radiation for acne, tonsils, arthritis? Y N

Have you lived/worked near a nuclear reactor? Y N

Have you traveled outside of the United States? Y N Where _____

Have you ever had a blood transfusion? Y N Any reactions? _____

REVIEW OF SYMPTOMS

NEURO

- Headaches
- Stiff Neck
- Stroke
- TIA
- Seizure
- Paralysis
- Double vision
- Urinary &/or Bowel Incontinence
- Fainting
- Migraines

LUNG

- Shortness of breath
- Chest Pain
- Fluid on the lung
- Bronchitis
- Chronic Cough
- Asthma
- Emphysema/COPD
- Blood Spitting
- Sleep Apnea
- Pneumonia

HEART

- High Blood Pressure
- Angina
- Heart Murmur
- Heart attack
- Heart Failure
- Arrhythmia
- Angioplasty
- Palpitations
- Phlebitis
- Blood Clots

G.I.

- Nausea
- Vomiting
- Vomiting blood
- Gallbladder problems
- Ulcers
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Difficulty swallowing
- Constipation
- Diarrhea
- Hemorrhoids
- Colitis
- Hiatal hernia
- Liver Disease
- Change in Appetite
- Screening Colonoscopy
- Other Endoscopy

G. U.

- Bladder/Kidney Infections
- Prostate problems
- Kidney stones
- Bladder problems
- Blood in urine
- Cystoscopies
- Genital problems

INFECTIOUS DISEASE

- Tuberculosis
- HIV
- Pneumovax
- Flu shot
- AIDS

JOINTS

- Osteo arthritis
- Rheumatoid arthritis
- Lupus
- Other

GYN

- C-Sections how many _____
- Pregnancies how many _____
- Menses age _____
- Menopause age _____
- Birth control pills
- Hormone replacement
- Hysterectomy
- Laparoscopies
- Last Mammogram
- Last Pap Smear

SKIN

- Chronic rash
- Psoriasis

ENDOCRINE

- Diabetes
- Require insulin
- Thyroid problems

PSYCHIATRIC

- Depression
- Suicide attempts
- Anxiety
- Problem sleeping
- Mood changes
- Panic attacks

CANCER Type: _____
When: _____
Type: _____
When: _____