PROVIDENCE
St. Patrick Hospital
Montana Cancer Center

Date completed/revised: ________________________

Patient Name: ____Age:____Date of Birth: ___________________

General and Referring Providers:____

Surgeon:___________________Medical Oncologist:___________________Radiation Oncologist:___________________

Other Providers Seen:____Dentist:___________________________

Pharmacy Choice and Location: ____

Reason for Visit: ____

____

<u>Medications</u>, <u>Vitamins, and Supplements</u> Please list or attach a complete list of all current. _____________________

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<u>Allergies/Reactions</u> – Please list all allergies and specific reactions:

□ Penicillin What happens? ___________________
□ Codeine What happens? ___________________
□ Sulfa What happens? ___________________
□ Aspirin What happens? ___________________
□ Iodine What happens? ___________________
□ X-ray contrast What happens? ___________________

□ Food ____________ What happens? ___________________

□ Other ____________ What happens? ___________________

<u>Personal Medical/Surgical History:</u>

Please list all of your past and current medical problems: ____

____

____

Please list all of your past surgeries: ____

____

Please list all of your past injuries: __________________________________

____

Version: 3-2-2016 **MCC STICKER**

Have you ever had any of the following: Facility Location Dates Doctor

Biopsies:____/__________________/_____________
Chemotherapy:____________________________________/____________________/_____________
Radiation Therapy:________________________________/__________________ _/_____________
Hormones:______________________________________/_____________________/_____________

Health Maintenance:

Date of last: Influenza Vaccine: ________________ Pneumonia Vaccine: _________________

Shingles Vaccine: ________________ Chest X-Ray: __________________________

Female:

Date of last mammogram: ________________
Date of last colonoscopy: ________________
Date of last bone density: ________________
Date of last PAP smear: ________________

Male:

Date of last PSA: _______________
Date last prostate/rectal exam: _______________
Date of last colonoscopy: _______________

Family History:

	Living/Dead	Age/Age at Death	Present Health/Cause of Death
Father	__________	______________	____
Mother	__________	_______________	____
Spouse	__________	_______________	____

Brothers Number Living ______________________ Health _______________________________________
Number Dead ______________________ Cause of Death ________________________________
Sisters Number Living ______________________ Health _______________________________________
Number Dead ______________________ Cause of Death ________________________________
Children Number Living ______________________ Health _______________________________________
Number Dead ______________________ Cause of Death ________________________________

Social History:

Are you: Single Married Separated Divorced Widowed Domestic Partnership

Do you live alone? Y N

Do you have any children? Y N How many? __________ Ages:______________

Who lives in your home? ________________________ Do you work? Part Time Full Time

Past or present occupation: ______________________________

Education (level completed) ________________________________

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Habits:

	Smoked	Chewed Tobacco	Drank Alcohol	Marijuana/Drugs
Do you or have you ever:	Y N	Y N	Y N	Y N
How many years?	________________	_______________	________________	______________
Do you still:	Y N	Y N	Y N	Y N
If you quit, when:	_________________	________________	________________	______________
How much per day:	_________________	________________	________________	______________
What type:	_________________	________________	________________	______________

Have you ever been told/asked to stop? Y N

Have you been in a screening or treatment program to quit? Y N

Are you interested in a program to quit? Y N

Constitutional/General Review:

Fatigue Y N

Fevers Y N

Night Sweats Y N

Are you Claustrophobic**:** Y N

Weight Change: Y N Gained?____ Lost?_____ How many pounds?______Over what time frame?_____________

Pain Y N Where does it hurt?__________________ When did it start?__________________________

What helps?_________________________ What makes it worse?______________________

What is the level (1-10) generally?______ What level at it's worst?_____________________

Do you feel safe at home?: Y N

Do you have difficulty reading? Y N

Do you drive? Y N

Do you have any driving problems? Y N

Please list any implanted devices, pacemaker or metal in your body: ____

Do you have a Durable Power of Attorney for Healthcare, Living Will, Five Wishes or POLST? _______________________

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Review of Systems:

1 Eyes/Ears/Nose/Throat/Mouth

Problems with eyes? Y N

What:______________________

Problems with ears? Y N

What: _____________________

Problems with nose? Y N

What: _____________________

Problems with throat/mouth? Y N

What: ____________________________

2 Neurological

Convulsions/Seizures Y N

Stroke/ Headaches Y N

Epilepsy Y N

3 Cardiovascular

High blood pressure Y N

Heart Attack Y N

Murmur Y N

Chest pains, angina Y N

Heart disease Y N

Fainting Y N

4 Respiratory

Bronchitis Y N

Emphysema Y N

Asthma Y N

Abnormal chest x-ray Y N

Cough Y N

Coughing up blood Y N

Difficulty breathing Y N

Chest pain Y N

Wheezing Y N

5 Gastrointestinal

Difficulty swallowing Y N

Stomach problems y N

Abdominal pain Y N

Nausea Y N

Vomiting Y N

Vomiting blood Y N

Change in bowel habits Y N

Constipation Y N

Diarrhea Y N

Blood in stools Y N

Jaundice, hepatitis Y N

Liver Disease Y N

6 Urinary

Loss of urine Y N

Frequent urination Y N

Nighttime urination Y N

How frequent? _____________________

Blood in urine Y N

Burning/painful urination Y N

Kidney disease/insufficiency Y N

Sexually active Y N

7 Hematologic/Immune

Bleeding tendency Y N

Anemia Y N

Enlarged lymph nodes Y N

Blood Transfusion? Y N

When? _____________________

8 Musculoskeletal

Muscle/Joint problems Y N

Bone problems Y N

Swelling Y N

9 Skin

Skin Cancer Y N

Other skin problems Y N

10 Psychiatric

Psychiatric therapy Y N

Psychiatric diagnosis y N

11 Endocrine

Diabetes Y N

Thyroid disease Y N

Hormonal problem Y N

12 Genital- Female

Vaginal Bleeding Y N

Vaginal discharge Y N

Do you menstruate? Y N

Irregular periods Y N

Painful periods Y N

Painful intercourse Y N

Number of pregnancies _______________

Number of deliveries _______________

Date of last period _______________

Birth Control Pills or Hormones Y N

How long ________Pill name______________

Any chance you are pregnant Y N

Method of Birth Control __________________

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