St Peter's Hospital
Cancer Care Center
ST PETER'S HEALTH PARTNERS

Patient Label:

PATIENT INSTRUCTIONS: Please make sure you complete all 5 pages *DO NOT detach the pages from the stub

INITIAL PATIENT HISTORY & PHYSICAL

M.D. ____

TODAY'S DATE:___________________________________

This form is to help your doctor give you better health care.

It is completely confidential and will be part of your medical record.

PLEASE MAKE SURE YOU COMPLETE ALL 5 PAGES

Race: __________________________Ethnicity: ______________________________ Preferred Language: _________________________________

Patient Name:____________________________D.O.B_____________

Address:____

City:_____________________State:__________Zip Code:__________

Nickname:____

Home Phone:____________________ Work phone:________________

Lifetime Occupation:______________________Retired ☐ Yes ☐ No

Employer:____

Primary Care Physician:______________________________________

WHICH PHYSICIAN REFERRED YOU TO US?

____

Please list any other physicians to whom you would like copies of information sent:

Name Address/City/State Problem Cared For

____

____

____

____

YOUR PHARMACY:

Name:____

Address:____

Phone:____

List of Allergies:_______________________________________

Manifestations:____

LATEX ALLERGY: ☐ Yes ☐ No

CONTRAST ALLERGY: ☐ Yes ☐ No

MARITAL STATUS:

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

LIVING ARRANGEMENT:

☐ Alone ☐ With Spouse / Significant Other

☐ Supervised Living ☐ Other: _______________________________

SERVICES IN YOUR HOME:

☐ None ☐ Aide ☐ Nurse ☐ Meals on Wheels

☐ Home Care Agency Name: _______________________________________

☐ Other: ____

PLEASE CHECK BOXES FOR ITEMS THAT YOU HAVE:

☐ Organ Donor Card ☐ Health Care Proxy ☐ Living Will ☐ Power of Attorney

☐ DNR ☐ DNI

Would you like more information of any of these? ☐ Yes ☐ No

Information Given: (Office Use Only)______________________________

LIST A PERSON WE MAY CONTACT IF WE ARE UNABLE TO REACH YOU:

Name:____

Address:____

____

Home Phone:____________________Work phone:____________________

Relationship:____

PERSON COMPLETING THIS FORM IF OTHER THAN PATIENT:

Name:____

REASON FOR SEEING DOCTOR: ____

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LIST ALL MEDICATIONS **YOU NOW** TAKE

(Including Non-Prescription Medications & Herbal Remedies)

Medication	Dose	Times Daily		Family History:	Present Age	Age at Death	Present Health or Cause of Death
				Father			
				Mother			
				☐ Brother ☐ Sister			
				☐ Brother ☐ Sister			
				☐ Brother ☐ Sister			
				☐ Brother ☐ Sister			
				☐ Brother ☐ Sister			
				Spouse			
				Child			
				Child			
				Child			
Are You On Oxygen? ☐ Yes ☐ No				Child			

DO ANY OTHER MEMBERS OF YOUR FAMILY HAVE A HISTORY OF CANCER OR BLOOD DISORDR? IF YES, PLEASE EXPLAIN.

____

PLEASE LIST ANY FAMILY MEMBERS WITH CANCER: ____________________Type: _________________; _________________; TYPE_________________

DO YOU NOW OR HAVE YOU EVER?	LIST YEAR LAST	FOR WOMEN ONLY
Smoked Cigarettes? ☐ Yes ☐ No ____Pkg/day____#Yrs. When Quit____ Consumed Alcohol? ☐ Yes ☐ No ____Drinks/Wk When Quit____ Consumed Coffee/Tea? ☐ Yes ☐ No ____Cups/Day Used Street/Illegal Drugs? ☐ Yes ☐ No Type______________________________	______Flu Vaccine ____Stool Blood Test ______Hepatitis Vaccine ____Rectal Exam ______Pneumonia Shot ____Colonoscopy ______Tetanus Shot ____Sigmoid Exam ______T.B. Test (PPD) ______Eye Exam ______Dental Exam ______Cholesterol Test	Age at 1st Menstrual Period_____Age at Menopause_____ If still Menstruating, Date of *Last* Period __________ Have you ever taken birth control pills? ☐ Yes ☐ No How Long?____Yrs. Do you now use birth control pills? ☐ Yes ☐ No Type________________________________ Have you *ever* taken hormone replacements? ☐ Yes ☐ No How Long?____**Yrs.** Are you *currently* taking hormone replacements? ☐ Yes ☐ No Type___________________________ Number of Pregnancies____Number of Live Births____ Age at 1st Child Birth____ Did you Breast Feed? ☐ Yes ☐ No How Long______________ **Year of Last:** ____Pap Test ☐ Normal ☐ Abnormal ____Breast Exam ☐ Normal ☐ Abnormal ____Mammogram ☐ Normal ☐ Abnormal Do you think you might be pregnant? ☐ Yes ☐ No

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MEDICAL HISTORY Answer these history questions by checking the appropriate boxes. **Have You Ever Had:**	∇ **FOR OFFICE USE ONLY** ∇
☐ A Heart Condition ☐ High Blood Pressure ☐ A Stroke	______
☐ A Lung Disorder	______
☐ Stomach / Gall Bladder Problems	______
☐ Jaundice / Hepatitis / Other Liver Disorders	______
☐ Ulcerative Colitis / Crohn's Disease	______
☐ Kidney / Bladder Problems	______
☐ Sexual Problems	______
☐ Venereal Disease / Herpes / A.I.D.S.	______
☐ Arthritis / Chronic Pain	______
☐ Frequent Headaches / A Nervous Disorder	______
☐ Seizure Disorder	______
☐ Depression / Anxiety	______
☐ Thyroid Problem	______
☐ Diabetes	______
☐ Skin Diseases (Eczema / Psoriasis / Hives	______
☐ Breast / Prostate Problems	______
☐ Anemia / Blood Disorders	______
☐ A Blood Transfusion	______
☐ Cancer	______
☐ Asthma / Hives	______
☐ Birth Defects / Inherited Diseases	______
☐ Measles / Mumps / Rubella / Chicken Pox	______
☐ Other Medical Problems: ______	______
☐ **NO KNOWN MEDICAL PROBLEMS**	______

HOSPITALIZATIONS: Please list those operations or serious illnesses that you had which required hospitalization. If you have had more than **four**, check this box ☐. **DO NOT INCLUDE PREGNANCIES HERE.**

Mo./Yr.	Illness or Operation	Complications Yes	Complications No
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

PRIOR CANCER TREATMENT

Mo./Yr.	Radiation / Chemo Site	Radiation / Chemo Type	Where Treated

History of Genetic Counseling: ☐ **Yes** ☐ **No**

Mo./Yr.	Where Treated

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ARE YOU **CURRENTLY** EXPERIENCING ANY OF THE FOLLOWING?

CHECK **ALL** APPLY.

∇ **OFFICE USE ONLY** ∇

CONSTITUTIONAL

☐ No problems or concerns
☐ Recent weight loss
☐ Recent weight gain
☐ Fevers / Chill
☐ Night sweat
☐ Excessive itching
☐ Food supplements
☐ On a diet now *Type:*_______________
__________ Number of meals daily

EYES

☐ No problems or concerns
☐ Glaucoma
☐ Cataracts
☐ Vision loss
☐ Other: ______________________

EAR, NOSE, MOUTH, THROAT

☐ No problems or concerns
☐ Hearing loss
☐ Dental problem
☐ Hoarseness
☐ Nose bleeds
☐ Other:______________________

CARDIOLOGY

☐ No problems or concerns
☐ High blood pressure
☐ Heart murmur
☐ Rapid / Irregular heart beat
☐ Chest pain / Tightness
☐ Pacemaker / Defibrillator
☐ Leg cramps at night
☐ Other:______________________

RESPIRATORY

☐ No problems or concerns
☐ Asthma / Bronchitis / Emphysema
☐ Shortness of breath
☐ Cough that produces blood
☐ Other:______________________

GENITOURINARY

☐ No problems or concerns
☐ Difficulty urinating
☐ Frequent / Painful urination
☐ Recurrent bladder infection
☐ Vaginal itching / Discharge
☐ Sexual problems
☐ Blood in urine
☐ Other:______________________

MUSCULOSKELETAL

☐ No problems or concerns
☐ Difficulty walking
☐ Joint aches or stiffness
☐ Painful legs / Feet
☐ Back ache / Pain
☐ Joint Replacements
☐ Other:______________________

NEUROLOGIC

☐ No problems or concerns
☐ Difficulty concentrating
☐ Headache
☐ Dizziness / Fainting / Blackouts
☐ Numbness hands / feet
☐ Seizures / Convulsions
☐ Memory Changes

Do you have pain? ☐ Yes ☐ No
Location:______________________

Please rate your pain:

0----1----2----3----4----5----6----7----8----9----10
None **Worst**

☐ Other:______________________

PSYCHOSOCIAL

☐ No problems or concerns
☐ Nightmares
☐ Anxious / Nervous
☐ Trouble sleeping
☐ Lonely / Depressed
☐ Work / Family Problems
☐ Tire easily
☐ Other:______________________

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GASTROINTESTINAL

- ☐ No problems or concerns
- ☐ Loss of appetite
- ☐ Heartburn or indigestion
- ☐ Stomach pain or discomfort
- ☐ Frequent nausea / Vomiting
- ☐ Recurrent diarrhea / Constipation
- ☐ Bloody stools
- ☐ Black, tarry stools
- ☐ Difficulty swallowing
- ☐ Other:________________________

(PLEASE COMPLETE THE RIGHT COLUMN)

∇ OFFICE USE ONLY ∇

ENDOCRINE

- ☐ No problems or concerns
- ☐ Thyroid problems
- ☐ Blood sugar problems
- ☐ Excessive sweating
- ☐ Other:________________________

SKIN / BREAST

- ☐ No problems or concerns
- ☐ Sores / Rashes
- ☐ Moles
- ☐ Nipple discharge
- ☐ Change in breast size
- ☐ Lump / Pain
- ☐ Other:________________________

HEMATOLOGIC / LYMPHATIC

- ☐ No problems or concerns
- ☐ Easy bleeding / Bruising
- ☐ Anemia or blood problem
- ☐ Frequent infections
- ☐ Swelling of glands
- ☐ Swelling of hands / feet
- ☐ Other:________________________

ALLERGIC / IMMUNOLOGIC

- ☐ No problems or concerns
- ☐ Facial swelling
- ☐ Tightening of throat
- ☐ Hives
- ☐ Other:________________________

PLEASE CHECK OFF THE BOX WHICH BEST DESCRIBES YOUR DAILY ACTIVITY:

☐	0	Fully active, able to carry on all pre-disease activities without restriction.
☐	1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature. For example: light housework, office work.
☐	2	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.
☐	3	Capable of only limited self-care, confined to bed or chair 50% or more of waking hours.
☐	4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.

____ ________________

M.D. Signature **Date**