New Patient Consultation Questionnaire

Age: _____ Date: _____

Have you ever received any prior Radiation Therapy? ❑ Yes ❑ No

What year and what facility did you get Radiation Therapy at? _____

If yes, what body region was treated? _____

Have you ever received chemotherapy? ❑ Yes ❑ No

Are you currently receiving or will you be receiving Chemotherapy? ❑ Yes ❑ No

When did you start Chemotherapy? _____ End Date? _____

Medical problems: ***(past and present)***

1. _____
2. _____
3. _____
4. _____
5. _____

Prior Surgeries and/or Biopsies: ***(include dates)***

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have any stents, pacemakers, defibrillators, ports, or implants? _____

Do you have an advanced directive or living will? ❑ Yes ❑ No

Medications and dosages: include regular medications and chemotherapy.

Please add vitamins, minerals, herbals, and over the counter medications on the back of the last sheet.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you have any medication allergies? ❑ Yes ❑ No

If yes, please list: _____

What reaction did you experience? _____

Latex Allergy? ❑ Yes ❑ No IV Contrast Allergy? ❑ Yes ❑ No

RN/NP/PA/MD Initials: _____

FAMILY HISTORY: (Blood relatives)

A. Any family members with cancer history? ❑ Yes ❑ No
Comments: _____

B. Father: ❑ Alive Age _____ ❑ Deceased Age ____ Cause: _____

C. Mother: ❑ Alive Age _____ ❑ Deceased Age ____ Cause: _____

D. Siblings: # of Sisters: _____ # of Brothers: _____
Comments: _____

SOCIAL HISTORY:

A. Occupation: _____

B. Currently Employed? ❑ Yes ❑ No

C. City of Residence: _____

D. Who do you live with? _____

E. Are you an active smoker? ❑ Yes ❑ No Are you a former smoker? ❑ Yes ❑ No

If you smoke or have smoked, how many packs per day did/do you smoke? _____

How many years have you smoked? _____ When did you stop smoking? _____

Do you use or have you used any other Tobacco products? _____

F. Any history of drug abuse/addiction? ❑ Yes ❑ No

G. How many alcoholic beverages do you drink per week? _____

H. Marital Status: ❑ Married ❑ Single ❑ Widow/Widower
❑ Divorced ❑ Significant Other

I. Children: ❑ Yes ❑ No How many: _____

1. Primary Care Physician _____
   Address: _____
2. Medical Oncologist _____
   Address: _____
3. Surgical Oncologist _____
   Address: _____
4. Other Physician _____
   Address: _____

Who referred you to our practice? _____

RN/NP/PA/MD Initials: _____

Do you CURRENTLY have? *(If yes, check appropriate boxes.)*

GENERAL
- ❑ Fatigue
- ❑ Fever
- ❑ Weight Gain >10 pounds
- ❑ Weight Loss > 10 pounds
- ❑ Chills
- ❑ Night Sweats

SKIN
- ❑ Nail Changes
- ❑ New Lesions
- ❑ Rash
- ❑ Itching skin/head

HEENT
- ❑ Double Vision
- ❑ Visual Difficulties
- ❑ Decreased Vision
- ❑ Eye Pain
- ❑ Eye Redness
- ❑ Decreased Hearing
- ❑ Earache
- ❑ Ear Ringing
- ❑ Nose Bleeds
- ❑ Dry Mouth
- ❑ Hoarseness
- ❑ Oral Ulcers
- ❑ Sore Throat

RESPIRATORY
- ❑ Chronic Cough
- ❑ Decreased Exercise Tolerance
- ❑ Difficulty Breathing
- ❑ Coughing up Blood
- ❑ Sputum Production
- ❑ Wheezing

BREAST
- ❑ Breast Pain
- ❑ Arm Swelling
- ❑ Open Wound

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Leg Pains with walking
- ❑ Leg Swelling
- ❑ Night Awakening due to Trouble breathing
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ High Blood Pressure

GASTROINTESTINAL
- ❑ Abdominal Pain
- ❑ Change in Bowel Habits
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting
- ❑ Rectal Bleeding
- ❑ Trouble Swallowing
- ❑ Date of last colonoscopy _____

GENITOURINARY

Are you sexually active?
❑ Yes ❑ No
- ❑ Difficulty Starting/ Stopping Urinary Stream
- ❑ Increased Frequency
- ❑ Blood in Urine
- ❑ Loss of Bladder Control
- ❑ Nighttime Urination
- ❑ Urinary Retention
- ❑ Urethral Discharge

FEMALES ONLY
- ❑ Vaginal Discharge
- ❑ Menstrual Irregularities
- ❑ Last Menstrual Period? _____

Are you pregnant?
❑ Yes ❑ No

MALES ONLY
- ❑ Erectile Dysfunction
- ❑ Testicular Pain

MUSCULOSKELETAL
- ❑ Decreased Range of Motion
- ❑ Joint Pain
- ❑ Joint Redness
- ❑ Joint Swelling
- ❑ Joint Stiffness
- ❑ Muscle Aches/Pains
- ❑ Back Pain
- ❑ Bone Pain

NEUROLOGICAL
- ❑ Loss of Bowel Control
- ❑ Dizziness/Vertigo
- ❑ Headaches
- ❑ Numbness/Tingling
- ❑ Passing Out
- ❑ Seizures
- ❑ Tremor

PSYCHIATRIC
- ❑ Anxiety
- ❑ Change in Sleep Pattern
- ❑ Depression
- ❑ Hallucinations
- ❑ Suicidal Thoughts

ENDOCRINE
- ❑ Appetite Changes
- ❑ Cold Intolerance
- ❑ Increased Thirst
- ❑ Increased Urination
- ❑ Hair Changes

HEMATOLOTY
- ❑ Easy Bruising
- ❑ Enlarged Lymph Nodes
- ❑ Prolonged Bleeding

PEDIATRIC PATIENTS

Immunization history
- ❑ MMR
- ❑ Chicken Pox

❑ None of the above

RN Notes: Did patient bring in any CD's/ films? ❑ Yes ❑ No

Were CD's/films returned to the patient? ❑ Yes ❑ No

_____

_____

_____