

# NYU Hospitals Center Cancer Center

Patient Identification

## PATIENT HISTORY INFORMATION

DATE: \_\_\_\_\_ NAME: LAST \_\_\_\_\_ FIRST: \_\_\_\_\_ INIT. \_\_\_\_\_

SEX:  M  F DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

MARITAL STATUS:  M  S  D  W

VISIT REASON: CONSULTATION  2<sup>ND</sup> OPINION  Referred by: \_\_\_\_\_

**ALLERGIES:**

Do you have any allergies?  Yes  No If yes, please list below and describe.

Drug/Substance	Allergic Reaction

**DO YOU PRESENTLY HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING?** (Please check Y or N)

- |  |   |
|--|---|
| <p><u>CHICKEN POX</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>TUBERCULOSIS</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>HEPATITIS</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>HEART DISEASE/CHEST PAIN</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>HIGH BLOOD PRESSURE</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>DIABETES</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>KIDNEY DISEASE</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>ARTHRITIS</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>OSTEOPOROSIS</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>OTHER(PLEASE EXPLAIN): _____</p> | <p><u>ABNORMAL BLEEDING/BLOOD CLOTTING</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>BOWEL PROBLEMS</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>CHRONIC INFECTIONS</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>THYROID DISEASE</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>ANEMIA</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>NEUROLOGICAL DISEASE</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>DEPRESSION/ANXIETY DISORDERS</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>HEARING PROBLEMS</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p><u>SKIN DISORDERS</u> <input type="checkbox"/> Y <input type="checkbox"/> N</p> |
|--|---|

**MEDICATIONS:**

Please list all medications, prescription and over the counter (including aspirin/vitamins), you take on a regular basis.

Drug	Dose	Frequency	Drug	Dose	Frequency
1			4		
2			5		
3			6		

Do you take any herbal medications and/or food supplements?  Y  N (if yes, please list below)

1			3		
2			4		

**PAIN:**

DO YOU HAVE PERSISTENT OR FREQUENT PAIN?  Y  N (if yes, complete the following)

Location on body \_\_\_\_\_ or mark on drawing

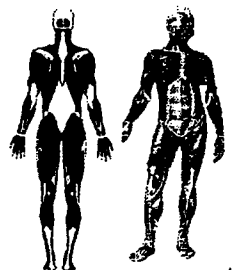
Scale/severity: please circle one

\* 0 1 2 3 4 5 6 7 8 9 10 \*

←(no pain) (moderate) (distressing) (unbearable pain)→

Does pain affect your daily activities?  Y  N. Are you currently on any drugs for pain  Y  N

What makes pain worse \_\_\_\_\_ Better \_\_\_\_\_



PLEASE TURN OVER

Patient identifier:

**PAST HOSPITALIZATIONS AND SURGICAL PROCEDURES:**

DATE	FACILITY	PROCEDURE/REASON

**NUTRITION:**

Are you on a special diet?  Y  N

If YES, please describe \_\_\_\_\_

Usual Weight: \_\_\_\_\_

Recent weight changes -  None  Gain  Unintentional Loss

Difficulty swallowing/chewing?  Y  N

Do you use TPN/tube feeds?  Y  N

Are you interested in seeing a Nutritionist?  Y  N

**ADVANCE DIRECTIVES:**

Do you currently have a Living Will, or Health Care Proxy for your health care decisions? \* Y  N

\*If Yes, Specify \_\_\_\_\_

\*\*If YES: do we have a copy?  Y  N

**\*\* Please provide a copy for the medical record to your nurse or social worker**

Do you have a power of attorney?  Y  N

Are you interested in seeing someone to discuss advanced directives?  Y  N

**LEARNING/CULTURAL NEEDS**

What is your primary language? \_\_\_\_\_ Translator needed?  Y  N

Are there any cultural/religious practices that you would like us to be aware of before treatment?  Y  N (if yes, list)

**SOCIAL HISTORY:**

Please describe your smoking history.

Current smoker  Ex-smoker (quit date \_\_\_\_\_)  Never smoked

\_\_\_\_\_ packs per day for \_\_\_\_\_ years  Cigarettes  Pipe  Cigar

Please describe your use of alcohol. social  weekly  1-2 glasses per day  2+ per day

Your current living arrangement is -  Live Alone  Live w/ Spouse  Live with Family/Friend  Other

Do you live with children 18 years or younger?  Y  N

Do you walk: without assistance  up with assistance  wheelchair  walker  cane  other \_\_\_\_\_

Are you interested in seeing a Social Worker?:  Y  N

**OTHER PHYSICIANS THAT ARE PRESENTLY CARING FOR YOU:**

ID. NAME	ADDRESS	PHONE #

**PAIN SCALE ALERT VALUE** \_\_\_\_\_ MD informed

**REFERRALS:** NUTRITION  PSYCHO-SOCIAL/HOMECARE  PAIN MANAGEMENT

N NAME (Print) \_\_\_\_\_ RN SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

2/23/03 JH



- Complete as best you can
- Your answers help us assess your case and in making recommendations

**HEALTH HISTORY QUESTIONNAIRE** page 1

**PERSONAL INFORMATION**

Your Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Age \_\_\_\_\_

Street Address/Apt. No \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Mobile Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Email Address \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Contact's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Age \_\_\_\_\_

Street Address/Apt. No \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_

**PHYSICIAN INFORMATION**

How were you referred to the NYU Clinical Cancer Institute?  Physician  Self/Other

If referred by physician, date referred: \_\_\_\_\_

Physician's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Age \_\_\_\_\_

Street Address/Suite No. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone \_\_\_\_\_ Office Fax \_\_\_\_\_ E-mail Address \_\_\_\_\_

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**HEALTH HISTORY QUESTIONNAIRE** page 2

**DO YOU HAVE A PRIMARY CARE PHYSICIAN?**  Yes  No

Physician's Last Name	First Name	Middle Initial
Street Address/Suite No.	City	State Zip
Office Phone	Office Fax	E-mail Address

**DOES YOUR INSURANCE REQUIRE REFERRALS FOR OFFICE VISITS AND/OR TESTS?**  Yes  No

**List all other physicians who should receive results of your consultation at the Institute**

Physician's Last Name	First Name	Middle Initial
Street Address/Suite No.	City	State Zip
Office Phone	Fax	E-mail Address

Physician's Last Name	First Name	Middle Initial
Street Address/Suite No.	City	State Zip
Office Phone	Fax	E-mail Address

Physician's Last Name	First Name	Middle Initial
Street Address/Suite No.	City	State Zip
Office Phone	Fax	E-mail Address

Physician's Last Name	First Name	Middle Initial
Street Address/Suite No.	City	State Zip
Office Phone	Fax	E-mail Address

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# NYU Hospitals Center Clinical Cancer Center

160 E. 34th Street  
New York, NY 10016

## HEALTH HISTORY QUESTIONNAIRE page 4

### SURGERY

Have you ever had cancer surgery? If yes, describe below  Yes  No

Month/Year of Surgery	Area of Body Treated	Hospital	Physician

Describe any problem(s) you experienced during or after surgery:

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### RADIATION THERAPY

Have you ever had radiation therapy? If yes, describe below  Yes  No

Start Date - End Date	Area of Body Treated	Hospital	Physician
-			
-			
-			
-			

Describe any problem(s) you experienced during or after therapy:

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### CHEMOTHERAPY

Have you ever had chemotherapy? If yes, describe below  Yes  No

Start Date - End Date	Area of Body Treated	Hospital	Physician
-			
-			
-			
-			

Describe any problem(s) you experienced during or after chemotherapy:

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**HEALTH HISTORY QUESTIONNAIRE** page 5

**MEDICAL HISTORY: NONCANCER**

How was your health before your diagnosis?

Excellent  Good  Fair  Poor

How do you feel right now?

Excellent  Good  Fair  Poor

**Medical illnesses or Conditions:** List all noncancer illnesses or conditions (for example, diabetes, heart disease, high blood pressure) starting with the most recent.

Illness/Condition	Date Diagnosed	Treatment	Physician

**Hospitalizations & Operations:** List all noncancer hospitalizations and operations starting with most recent.

Reason for Hospitalization	Date(s) Hospitalized	Hospital	Physician

**Medications:** List all medications you are now taking (including vitamins and nonprescription drugs) and doses starting with most recent. **Bring all medications to your first visit.**

Medication	Date Prescribed	Dosage	Frequency

**Medical Allergies:**

Yes      No      Don't Know

Are you allergic to the dye used in X-rays?

Are you allergic to latex?

Are you allergic to medications (for example, Penicillin)?

Medication	Date of Reaction	Type of Allergic Reaction

**Continued >**



**HEALTH HISTORY QUESTIONNAIRE** page 6

**FAMILY HEALTH HISTORY**

Include blood relatives only, whether or not diagnosed with cancer. Do not include anyone adopted, foster, step-relatives or those related by marriage.

Relative	Age	Alive?		Had Cancer?		If Yes, List Type(s) (breast, lung)	Other Medical Problems?		If Yes, List Conditions (heart disease, kidney failure)
		Yes	No	Yes	No		Yes	No	
Your Mother									
Your Father									
Your Mother's Mother									
Your Mother's Father									
Your Father's Mother									
Your Father's Father									
Daughter 1									
Daughter 2									
Daughter 3									
Daughter 4									
Son 1									
Son 2									
Son 3									
Son 4									
Sister 1									
Sister 2									
Sister 3									
Sister 4									
Brother 1									
Brother 2									
Brother 3									
Brother 4									
Other Blood Relatives:									

Other illnesses that "run" in your family:

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Clinical Cancer Center**

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**HEALTH HISTORY QUESTIONNAIRE page 7**

**SOCIAL HISTORY**

Marital Status:	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Number of dependents at home:					
Education:	<input type="checkbox"/> Grade school	<input type="checkbox"/> High School	<input type="checkbox"/> College	<input type="checkbox"/> Other	
Main Language:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Arabic	<input type="checkbox"/> Other	
Need a translator?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Have a reliable transportation to medical appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Have insurance coverage for prescription drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Have advanced directive/durable power of attorney? (If yes, bring to appointment)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Have family/friends to help you during your treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Have emotional support from family members/friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Have someone living with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
If yes, name				Phone ( )	
Need help coping with your diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
If yes, are you receiving help?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
If yes, name				Location	
Does your family need help coping with your diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Are you currently being abused physically, sexually or emotionally?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Would you like to speak with a cancer counselor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				

**OCCUPATION/WORK HISTORY & ENVIRONMENTAL EXPOSURE**

What is your occupation?					
Did you previously have a different occupation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Were you ever exposed to the following (work or elsewhere):					
Asbestos	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Chronic Fumes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Chronic Dust	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Toxic Chemicals	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Other (list)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				

**TOBACCO, ALCOHOL & OTHER SUBSTANCE ABUSE**

Do you use <input type="checkbox"/> cigarettes <input type="checkbox"/> cigars <input type="checkbox"/> pipe <input type="checkbox"/> chewing tobacco <input type="checkbox"/> snuff (check all that apply)					
How much do you use per day? Number of years?					
Did you use <input type="checkbox"/> cigarettes <input type="checkbox"/> cigars <input type="checkbox"/> pipe <input type="checkbox"/> chewing tobacco <input type="checkbox"/> snuff (check all that apply)					
How much did you use per day? Number of years? When did you stop?					
Have you been exposed to secondhand smoke at home or work?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Do you drink alcoholic beverages <input type="checkbox"/> regularly <input type="checkbox"/> on social occasions only?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Has alcohol ever interfered with your personal/professional life?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Did you or do you use marijuana?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Have you ever used cocaine, heroine or other illegal substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				

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**HEALTH HISTORY QUESTIONNAIRE page 8**

**REVIEW OF SYSTEMS** - If you are currently experiencing or previously experienced, any of the following to a significant degree, explain on the back of this page

	Yes	No	Don't Know
<b>General</b>			
Fever			
Sweats			
Weakness			
Fatigue			
Weight Loss			
<b>Pain</b>		<b>Level</b>	
Average Pain most days		<b>0 1 2 3 4 5 6 7 8 9 10</b> none/low worst	
Where does it hurt?			
Staying the same or getting worse?	<input type="checkbox"/> same	<input type="checkbox"/> worse	
What are you taking for it?			
Does this help?			
<b>Skin</b>			
Excessive sun exposure			
Blistering/burns			
Use sunscreen			
Dark or pigmented skin lesion			
Dark or pigmented skin lesion removed			
Melanoma			
Bleeding skin lesion			
Skin cancer			
Psoriasis			
Chronic rash			
Vitiligo			
Birthmark			
Family member with dysplastic nevus syndrome			

	Yes	No	Don't Know
<b>Eyes</b>			
Lost Vision			
Wear glasses			
Cataracts			
Glaucoma			
<b>Ears</b>			
Lost hearing			
Ringing in your ears			
Sinuses			
Sinus trouble			
Nosebleeds			
<b>Moth</b>			
Dental problems			
Wear dentures			
Sore tongue			
<b>Neck</b>			
Swollen glands			
Laryngitis			
Hoarseness			
<b>Breast</b>			
Breast biopsy			
Breast cancer			
Nipple discharge			
Breast lumps			
Cystic breast disease			
Breast infection			
Mammogram			
Hormone replacement therapy			
Breastfed any children			
If yes, how long in months:			

**Continued >**



**HEALTH HISTORY QUESTIONNAIRE** page 9

**REVIEW OF SYSTEMS** - If you are currently experiencing or previously experienced, any of the following to a significant degree, explain on the back of this page

	Yes	No	Don't Know
<b>Lungs</b>			
Cough everyday			
Cough, produce sputum (phlegm) most days			
<b>Blood in your sputum</b>			
Pneumonia			
Bronchitis			
Emphysema			
Tuberculosis			
Asthma			
Short of breath with activity			
Short of breath at rest			
Frequent colds			
<b>Heart, Blood Vessels</b>			
Chest Pain (Angina)			
Chest pressure			
Heart Attack			
Short of breath at night			
Heart murmur			
Rapid heartbeat that required treatment			
Swollen ankles			
Leg cramps at night			
Leg cramps when walking			
Rheumatic fever			
Congenital heart disease			

	Yes	No	Don't Know
<b>Gastrointestinal</b>			
Lost appetite			
Recent weight change If yes, amount ____ loss ____ gain			
<b>Excessive saliva</b>			
<b>Swallowing problems</b>			
Difficult If yes, date started			
Solids stick If yes, where			
Pain If yes, date started			
Choking			
Food comes out your nose			
Heartburn			
Ulcer			
Endoscopy (upper GI colonoscopy, etc)			
Nausea			
Vomiting			
Vomit blood			
Diarrhea			
Upset stomach (food related)			
Constipation			
Black bowel movements			
Yellow or jaundiced			
Hepatitis			
Gall bladder problems			
Cirrhosis			

Continued >



**HEALTH HISTORY QUESTIONNAIRE** page 10

**REVIEW OF SYSTEMS** - If you are currently experiencing or previously experienced, any of the following to a significant degree, explain on the back of this page

<b>Genitourinary</b>	Yes	No	Don't Know
Kidney problems			
Frequent urination			
Painful urination			
Urinate at night			
Blood in urine			
Kidney stones			
<b>Genitourinary: Men</b>			
Difficulty starting/stopping urination			
Sexual performance problems			
Elevated prostate blood test (PSA)			
Prostate biopsy			
Swollen/painful testicle			
<b>Genitourinary: Women</b>			
Age started menstruating			
Irregular or painful menstruation			
Still menstruating			
Date of last menstrual period			
Age stopped menstruating			
Painful intercourse			
Bleeding following intercourse			
Endometriosis			
Did your mother take estrogen when she was pregnant with you?			
Date of your last pap smear			
Pregnant now			
Number of pregnancies			
Number of children			
Number of miscarriages			
Age at first pregnancy			

	Yes	No	Don't Know
<b>Neurological</b>			
Dominant hand <input type="checkbox"/> right <input type="checkbox"/> left			
Seizure			
Double vision			
Blurred vision			
Weakness in extremity			
Numbness			
Stroke			
Migraine headaches			
Forgetfulness			
Confusion			
<b>Hematologic</b>			
Blood transfusion			
Rejected as blood donor			
Bruise or bleed easily			
Anemic			
Take aspirin or nonsteroid anti-inflammatory (Motrin, Advil, Alleve)			
Swollen glands			
<b>Extremities &amp; Back</b>			
Arthritis			
Back pain			
Broken bone			
Swollen joints			
<b>Endocrine/Glands</b>			
Diabetes mellitus			
Thyroid disease			
Other endocrine/gland conditions (list)			

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## HEALTH HISTORY QUESTIONNAIRE page 11

**REVIEW OF SYSTEMS** - If you are currently experiencing or previously experienced, any of the following to a significant degree, explain on the back of this page

	Yes	No	Don't Know
<b>Do you have difficulty performing these activities by yourself?</b> (check all that apply)			
Bathing			
Dressing			
Eating			
Housekeeping			
Using toilet			
Walking			
Others (list)			

	Yes	No	Don't Know
<b>Are you interested in more information about the following?</b> (check all that apply)			
Cancer screening			
Diabetes			
Exercise			
Living wills			
Nutrition			
Quitting smoking			
Safe sexual practices			
Street			
Violent/abusive behavior			
Weight control			
Other (list)			

**Additional questions you have:**

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Physician Reviewer

RN Reviewer

Date