Cancer Care Institute – Intake Questionnaire

For office use only:

Diagnosis ICD-9 Code	Date

Date	
Patient	
Birth date	
Age	

Referring and/or Primary Care Physician:	

Other Physicians:	

What brings you here today?	

Have your ever received radiation therapy?		When		Where	

Have your ever received chemo therapy?		When		Where	

Do you or have you ever had:

Diabetes☐ High blood pressure☐ Heart attacks☐ Ulcerative colitis☐
Scleroderma☐ Rheumatoid arthritis☐ Lupus☐ Crohn's disease☐

Please List Any:

Year	Illness/Operations/Hospitalization/Biopsy	Hospital/City/State

Date of last chest X-ray:		
Other X-rays/scans:		
Other X-rays/scans:		

Recent weight loss		Approximate amount		Current weight	

Medications you are currently taking & dose:	Allergies to drugs/other things:

Does anyone in your family have cancer? Please list	

Social History

Date	
Patient	

Employment / Profession:	
Hobbies:	
Activities:	
With whom do you live?	

Total number of others in house / apartment:	
Do you provide care and or financial support to others?	
Do others provide you with care and or financial support?	

Do you use/or used in the past?	How much / often?	For how long / When did you quit?
Coffee yes ☐ no☐		
Tea yes ☐ no☐		
Tobacco yes ☐ no☐		
Alcohol yes ☐ no☐		
Recreational drug yes ☐ no☐ (i.e. Marijuana) please identify:		

Marital Status: Single☐ Married☐ Divorce☐ Widow☐

Spouse's Name:	

	Age now / Age at death	State of health / Cause of death
Spouse		
Children		

Functional Assessment

Difficulty with mobility (ambulation, transfer, etc.?)	

Use: Cane☐ Walker☐ Wheelchair☐ Personal assistance for ambulation☐

Difficulty with activities of daily living (dressing, bathing, feeding self?)	
Difficulty with speech or communication?	

Pain Assessment (pain scale level 1-10; 1 is least pain, 10 is worse pain)

Do you have pain Acute ☐ Chronic ☐ Constant☐ Intermittent☐ Breast pain☐

Quality of pain: stabbing☐ burning☐ pressure type☐ dull☐ sharp☐

Location of pain:	
How is it aggravated	
How is it relieved or improved	

Effectiveness of pain medication?	No effect☐ Little☐ Some☐ Relieves most pain☐ Complete relief☐

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Have you recently had:	Night sweats☐ Fevers☐ Decreased energy level☐
	Loss of appetite☐ Weight loss more than 10 pounds☐

Body Systems

Head	Stroke☐ Paralysis☐ "pins & needles" feeling☐ Headache☐ Dizziness☐ Seizure☐ Depression☐ Passed out☐ Confusion☐ Other:
Eyes	Blurring☐ Itching☐ Redness☐ Loss of vision☐ Double vision☐ Halos around light☐ Other:
Ears	Earache☐ Ringing☐ Loss of hearing☐ Other:
Nose	Drainage☐ Blockade☐ Frequent cold☐ Frequent nose bleed☐ Other
Mouth/throat	Loss of teeth☐ Denture☐ Sores☐ Bleeding gum☐ Hoarseness☐ Trouble speaking☐ Pain or difficulty swallowing☐ Other:
Chest	Shortness of breath☐ Pain☐ Bloody sputum☐ Blood in cough☐ Wheezing☐ Night sweat☐ Other:
Heart	Heart attack☐ Chest pain☐ Pacemaker☐ Palpitation☐ Leg cramp☐ Numbness in arm or leg☐ High blood pressure☐ Swelling of feet☐ Varicose vein☐ Other:
G.I.	Ulcer☐ Indigestion☐ Nausea☐ Vomiting☐ Diarrhea☐ Constipation☐ Hemorrhoid☐ Difficulty swallowing☐ Abdominal pain☐ Stool change (tar-like or bloody)☐ Other:
G.U.	Burning on urination☐ Blood in urine☐ Infection☐ Kidney stone☐ Dribbling☐ Frequent urination☐ Trouble with stream☐ Nighttime urination☐ Sexually active? Y / N Sexual problem? Other:
Muscle/Bone	Arthritis☐ Pain☐ Stiffness☐ Swelling of joint or bone☐ Weakness in arm/leg☐ Numbness in arm /leg☐ Swelling in arm/leg☐ Other:
Skin	Rash☐ Itch☐ Bruise☐ Biopsy☐ Lump/bump☐ Bleed easily☐ Other:
Breast	Lump/bump☐ Biopsy☐ Pain☐ Discharge☐ New dimple☐ Blood in nipple☐ Skin change in breast☐ Puckering change in nipple☐ Other:
	Do you practice breast self exam? Yes☐ / No☐ When was your last mammogram? Where
GYN	Pap smear☐ Vaginal bleeding☐ Vaginal discharge☐ Number of : Pregnancies Deliveries Stillbirths Did you nurse? Yes☐ / No☐ Are you currently menstruating? Yes☐ / No☐ Date of last period? Age of menarche: Age of menopause: Do / did you use hormone replacement therapy? Yes☐ / No☐ If yes, for how long?

Is there anything that has not been addressed by this questionnaire that you feel we should know?