St. Charles
CANCER CENTER
A DEPARTMENT OF ST. CHARLES BEND

Patient Label

PATIENT MEDICAL INFORMATION AND CARE PLANNING TOOL

Patient Name:_______________ **Date:**___________ **Age:** ___________

Date of Birth: ___________ Preferred Name:_______________ Preferred Language:_______________

Address:_______________ City:_______________ State:_______ Zip:___________

Phone:_______________ Cell Phone:_______________ Preferred Phone: ___________

Emergency Contact: _______________ Relationship: ___________

Email: _______________ ☐ If you would like to opt out of receiving e-mail notices about survivorship and support services, please check here.

Referring Doctor:_______________ Primary Care Doctor:_______________

Other doctors to receive copies of records : _______________

Chief complaint / history of present illness (Describe why you have been referred here): _______________

____

Symptom Review (Circle symptoms that apply):

GENERAL
Fevers
Night Sweats
Weight Loss
Fatigue
Pain

HEAD / NECK
Mouth Sores
Hoarse Voice
Poor Taste

GASTROINTESTINAL
Nausea
Diarrhea
Constipation
Abdominal Pain
Blood in Stools
Problems Swallowing
Heartburn
Cirrhosis
Difficulties that keep you from eating well & maintaining your weight.

CARDIOVASCULAR
Chest Pain / Angina
Irregular Beats
Racing / Fluttering
Murmur
Leg Swelling

RESPIRATORY
Short of Breath
Cough
Coughing Blood
Snoring

INFECTIOUS
HIV Risk / Exposure
TB Exposure
Hepatitis Exposure
Frequent Infections
Recent Antibiotics

ENDOCRINE
Thin Bones
Hot Flashes
Thyroid Problems

BONE / JOINTS
Bone Pain
Muscle Pain
Back Pain
Arthritis

HEMATOLOGY
Blood Clots:
DVT or PE
Abnormal bleeding
Big Lymph Glands
Anemia
Blood Disorder

URINARY
Burning / Pain
Blood in Urine
Kidney Stones
Frequent at Night
Dribbling
Incontinence

NEUROLOGIC
Headaches
Vision Changes
Numbness / Tingling
Weakness
Memory Changes
Hearing Problems
Seizures

SKIN
Moles
Change in Nail Texture
Eczema / Hives

IMMUNE
Scleroderma
Dermatomyositis
Inflammatory Bowel Disease
Crohn's Disease
Ulcerative Colitis

MALE
Erectile Dysfunction
Enlarged Prostate

FEMALE
Breast Lumps
Vaginal Bleeding / Spotting
Nipple Discharge

DO YOU HAVE ANY OF THE FOLLOWING?
Pacemaker
Ports
Implanted Devices
Catheter

FEMALE PATIENTS ONLY

Age of onset of first menstrual period: ___________ Pregnancies (#) ___________ Miscarriages (#) ___________

Age at first live birth ________ Did you breast feed? ☐Yes ☐No Total # of month's breast fed ___________

Years on birth control pills (#) _______________ Years on hormone replacement therapy (#) _______________

Last menstrual period (date) _______________

Date of your last mammogram _______________ Date of last Pap smear _______________

Are you pregnant? _______________ Are you using birth control? List: _______________

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FUNCTIONAL STATUS (Please circle the most appropriate number)

0 Fully active; no performance restrictions.
1 Strenuous physical activity restricted but walking and able to do light work.
2 Can care for self but unable to carry out any work; up > 50% of waking hours.
3 Capable of only limited self care; confined to bed or chair > 50% of waking hours.
4 Completely disabled; cannot carry out any self care; totally confined to bed or chair.

PAST MEDICAL HISTORY:

Past illnesses and chronic medical problems (year and type): ______________________________
____
____

Past operations (year and type): ______________________________
____
____

Other hospitalizations (name and location of hospital, date and reason): ______________________________
____
____

Have you had previous Chemotherapy Treatment? ☐ Yes ☐ No
Previous X-Ray treatment (including treatment for birthmarks, acne, etc.) radiation or cobalt treatment
☐ Yes ☐ No If Yes to either question, please describe: ______________________________
____
____

FAMILY HISTORY OF CANCER DIAGNOSIS

Relation	Age at Diagnosis	Location / Type of Cancer

SOCIAL / OCCUPATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Significant Other
Occupation / Former Occupation______________________________
Spouse's or Significant Other's Name and Occupation:______________________________
Number and ages of children: ______________________________
List your support system (friends, church, and other organizations): ______________________________
____
Please describe interests or hobbies you pursue with any regularity: ______________________________
____
Have you experienced any major life changes in the last few years? (e.g. moving, change of job, loss of close relative or friend) Please describe: ______________________________
Is your spirituality or religion an important part of your life? ☐ Yes ☐ No How are these beliefs and practices helpful to you? ______________________________
Are you currently in a relationship where you are physically hurt, threatened, or made to feel afraid?
☐ Yes ☐ No

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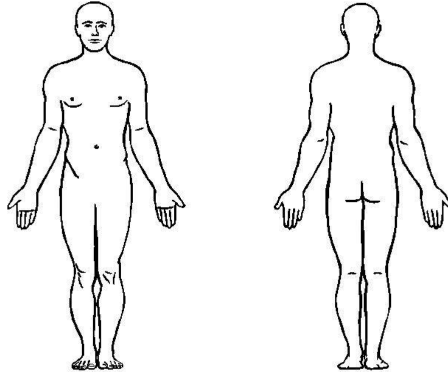
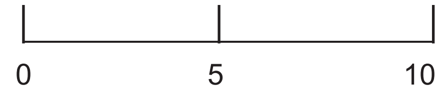
PAIN ASSESSMENT

Mark all your areas of pain with an "X"



Please rate your pain on a scale of 0 to 10.

0 = no pain 10 = worst pain



Pain medication used:

Short acting Medication __________________ How many in the past 24 hours ________________

Long acting Medication __________________

ALLERGIES TO MEDICATIONS:

Name	What happens to you when you take it?	Other / Non medication allergies

Our nurses will review current medications. Please list dietary supplements: ________________________

____

Would you like to speak with our oncology pharmacist to discuss how supplements may interact with your treatment? ☐ Yes ☐ No

HABITS (Please circle)

Have you used:

Cigarettes? No Yes How many per day? _______ For how many years?

Have you quit? No Yes If yes, when?

Other Tobacco No Yes How many per day? _______ For how many years?

Have you quit? No Yes If yes, when?

Do you drink alcoholic beverages? ☐ No ☐ Yes How many drinks per day? ____________________

Do you use marijuana? ☐ No ☐ Yes If Yes, describe: ______________________________

Have you ever used street drugs? ☐ No ☐ Yes If Yes, describe: ______________________________

Have you had any occupational/unusual exposure to asbestos or toxic chemicals? ☐ No ☐ Yes

If yes, describe: ____

You may be eligible for free or reduced Lung Cancer Screening if you meet all the criteria listed below:

- ☐ You are between 55 and 74 years old
- ☐ Are currently a smoker or have quit within the past 15 years
- ☐ Have smoked at least a pack of cigarettes a day for 30 + years
- ☐ Have no new symptoms of a lung condition or history of lung cancer

Our Cancer Screening Coordinator will contact you if you qualify.

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If you did not bring a medication list with you, please complete the medication list attached below.
** We do not have your medications on file**

Thank You

Date	Medication	Dose/Directions	Prescribed By	Reason for Taking

Please cross off any medications you are no longer taking.

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National Comprehensive Cancer Network®

NCCN Distress Thermometer for Patients

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress

10
9
8
7
6
5
4
3
2
1
0

No distress

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions
		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues
		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	**Spiritual/religious concerns**

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance abuse
❑	❑	Tingling in hands/feet

Other Problems: ______________________________

____

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) are a statement of evidence and consensus of the authors regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult the NCCN Guidelines® is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient's care or treatment. The National Comprehensive Cancer Network® (NCCN®) makes no representations or warranties of any kind regarding their content, use, or application, and disclaims any responsibility for their application or use in any way. The NCCN Guidelines are copyrighted by National Comprehensive Cancer Network®. All rights reserved. The NCCN Guidelines and the illustrations herein may not be reproduced in any form without the express written permission of NCCN. ©2013.