



Montana Cancer Center

Date completed/ revised: _____

Patient Name: _____ Age: _____ Date of Birth: _____

General and Referring Providers: _____

Surgeon: _____ Medical Oncologist: _____ Radiation Oncologist: _____

Other Providers Seen: _____ Dentist: _____

Pharmacy Choice and Location: _____

Reason for Visit: _____

Medications, Vitamins, and Supplements Please list or attach a complete list of all current. _____

Allergies/Reactions – Please list all allergies and specific reactions:

- Penicillin What happens? _____
- Codeine What happens? _____
- Sulfa What happens? _____
- Aspirin What happens? _____
- Iodine What happens? _____
- X-ray contrast What happens? _____
- Food _____ What happens? _____
- Other _____ What happens? _____

Personal Medical/Surgical History:

Please list all of your past and current medical problems: _____

Please list all of your past surgeries: _____

Please list all of your past injuries: _____

Habits:

	Smoked		Chewed Tobacco		Drank Alcohol		Marijuana/Drugs	
Do you or have you ever:	Y	N	Y	N	Y	N	Y	N
How many years?	_____		_____		_____		_____	
Do you still:	Y	N	Y	N	Y	N	Y	N
If you quit, when:	_____		_____		_____		_____	
How much per day:	_____		_____		_____		_____	
What type:	_____		_____		_____		_____	
Have you ever been told/asked to stop?				Y	N			
Have you been in a screening or treatment program to quit?			Y	N				
Are you interested in a program to quit?				Y	N			

Constitutional/General Review:

Fatigue: Y N Fevers: Y N Night Sweats: Y N

Are you Claustrophobic: Y N

Weight Change: Y N Unsure
Gained? _____ Lost? _____ How many pounds? _____ Over what time frame? _____

Are you eating less because of a decreased appetite? Y N

Pain: Y N Where does it hurt? _____ When did it start? _____
What helps? _____ What makes it worse? _____
What is the level (1-10) generally? _____ What level at it's worst? _____

Do you feel safe at home?: Y N

In the past month, have you wished you were dead or wished you could go to sleep and not wake up? Y N

In the past month, have you actually had any thoughts of killing yourself? Y N

Do you have difficulty reading? Y N

Do you drive? Y N Do you have any driving problems? Y N

Please list any implanted devices, pacemaker or metal in your body: _____

Do you have an Advanced Directive, Durable Power of Attorney for Healthcare, Living Will? Y N

Do you have a POLST? Y N

Is there anyone you do NOT wish us to share your healthcare information with? Y N

If yes, please list name(s) and relationship to you: _____

Review of Systems:

1 Eyes/Ears/Nose/Throat/Mouth

Problems with eyes? Y N
What: _____
Problems with ears? Y N
What: _____
Problems with nose? Y N
What: _____
Problems with throat/mouth? Y N
What: _____

2 Neurological

Convulsions/Seizures Y N
Stroke/ Headaches Y N
Epilepsy Y N

3 Cardiovascular

High blood pressure Y N
Heart Attack Y N
Murmur Y N
Chest pains, angina Y N
Heart disease Y N
Fainting Y N

4 Respiratory

Bronchitis Y N
Emphysema Y N
Asthma Y N
Abnormal chest x-ray Y N
Cough Y N
Coughing up blood Y N
Difficulty breathing Y N
Chest pain Y N
Wheezing Y N

5 Gastrointestinal

Difficulty swallowing Y N
Stomach problems y N
Abdominal pain Y N
Nausea Y N
Vomiting Y N
Vomiting blood Y N
Change in bowel habits Y N
Constipation Y N
Diarrhea Y N
Blood in stools Y N
Jaundice, hepatitis Y N
Liver Disease Y N

6 Urinary

Loss of urine Y N
Frequent urination Y N
Nighttime urination Y N
How frequent? _____
Blood in urine Y N
Burning/painful urination Y N
Kidney disease/insufficiency Y N
Sexually active Y N

7 Hematologic/Immune

Bleeding tendency Y N
Anemia Y N
Enlarged lymph nodes Y N
Blood Transfusion? Y N
When? _____

8 Musculoskeletal

Muscle/Joint problems Y N
Bone problems Y N
Swelling Y N

9 Skin

Skin Cancer Y N
Other skin problems Y N

10 Psychiatric

Psychiatric therapy Y N
Psychiatric diagnosis y N

11 Endocrine

Diabetes Y N
Thyroid disease Y N
Hormonal problem Y N

12 Genital- Female

Vaginal Bleeding Y N
Vaginal discharge Y N
Do you menstruate? Y N
 Irregular periods Y N
 Painful periods Y N
Painful intercourse Y N
of pregnancies ____ # of deliveries ____
Date of last period _____
Birth Control Pills or Hormones Y N
How long _____ Pill name _____
Any chance you are pregnant Y N
Method of Birth Control _____