CUMC Cancer Center- Review of Systems and Health History

DATE_____

***Name*_____ *Date of birth*_____ *AGE*_____**

1. Performance Status Scale: Circle the number below that best describes your level of functioning NOW:

0	**Asymptomatic** and fully active
1	**Symptomatic**; fully ambulatory; restricted only in physically strenuous activity
2	**Symptomatic**; ambulatory; capable of self-care; more than 50% of waking hours are spent out of bed
3	**Symptomatic**; limited self-care; spends more than 50% of time in bed, but not bedridden
4	**Completely disabled**; no self-care; bedridden

2. Pain Assessment: example: no pain 0 –1—2—3—4—5—6—7—8—9—10 worst pain ever

Rate your CURRENT daily (average) pain level: (0 to 10) _____ LOCATION of pain:_____

TYPE of pain: (burn,sting,cramp…)_____

Rate your average pain level LAST 3 MONTHS: (0 to 10) _____ _____

What make your pain worse?_____ What makes your pain better?_____

3. Are you working? check one: No____ Part time____ Full time____ Your occupation:_____

4. Describe your…

appetite incl. problems eating:

DO YOU HAVE A FEEDING TUBE? Y N TYPE:_____ LOCATION:_____

bowel function incl. frequency/character:

DO YOU HAVE AN OSTOMY? Y N TYPE:_____ LOCATION:_____

bladder function incl. leakage, frequency:

5. Current Height: _____ **Current Weight:** _____ (weight 2 months ago:_____)

6. List ALL Current Medications: **MEDICATION ALLERGIES:**_____

_____

_____

7. Current Treatment/Chemo:_____

8. VACCINATIONS: **Current?** (circle one) Y N **Pneumovax** done on date_____ (if not done yet, ask your local doctor about this)

9. Past Surgical History: LIST ALL SURGERIES—BE AS COMPLETE AS POSSIBLE—USE EXTRA PAGE IF NECESSARY

Date	Name of Operation	Hospital, City & State, Phone No.	Surgeon

10. Current Medical Problems: Asthma? Y N COPD? Y N Heart attack? Y N High Blood Pressure? Y N Diabetes? Y N

List other medical problems:_____

HISTORY Of MRSA (methicillin-resistant staph aureus) INFECTION? Yes No Body region of infection?_____

HISTORY Of VRE (vancomycin-resistant enterococcus) INFECTION? Yes No Body region of infection?_____

11. Family History: List cancer and other health problems your family members have had, and if deceased, indicate age and cause of death.

Father_____

Mother_____

Brothers_____

Sisters_____

Children_____

Family members with (check if positive): _____ excessive bleeding problems?

_____ blood clots in legs or lungs?

_____ reaction to surgical anesthesia?

Reviewed By: _____Date_____

Reviewed By: _____Date_____

Patient Signature_____ Reviewed By: _____Date_____

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Name: _____ ***Date of birth:***_____ ***AGE***_____

Please answer all questions below and complete requested history information:

Constitutional Symptoms

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus or rhinitis	No	Yes
Nose bleeds	No	Yes
Bleeding gums	No	Yes
Bad breath or taste	No	Yes
Sore throat or voice change	No	Yes
Difficulty swallowing	No	Yes

Neurological

Frequent headaches	No	Yes
Light headed/dizzy	No	Yes
Convulsions/seizures	No	Yes
Numbness/tingling	No	Yes
Tremors	No	Yes
Paralysis or Stroke	No	Yes
Head Injury	No	Yes

Musculoskeletal

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness muscles/joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty walking	No	Yes

Cardiovascular

Heart Trouble	No	Yes
Chest pain, Angina pectoris	No	Yes
Palpitation	No	Yes
Swelling feet, ankles, hands	No	Yes
Heart murmur	No	Yes
Hypertension	No	Yes

Endocrine

Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat/Cold intolerance	No	Yes
Change in hat/glove size	No	Yes

Gastrointestinal

Loss of Appetite	No	Yes
Change in bowel movement	No	Yes
Painful bowel movements	No	Yes
Nausea/Vomiting	No	Yes
Frequent diarrhea	No	Yes
Constipation	No	Yes
Rectal bleeding	No	Yes
Blood in stool	No	Yes
Abdominal Pain	No	Yes
Peptic Ulcer	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Nervousness or Insomnia	No	Yes
Depression/Anxiety	No	Yes
Mental Illness	No	Yes
Psychiatric hospitalization	No	Yes

Eyes

Eye diseases or injury	No	Yes
Wear glasses/contacts	No	Yes
Blurred or Double Vision	No	Yes
Glaucoma	No	Yes

Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Difficulty in urination	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male testicle pain	No	Yes
Female pain with period	No	Yes
Female irregular period	No	Yes
Female Vaginal discharge	No	Yes
Female-# of pregnancies	_____	
Female-#of miscarriages	_____	
Female-date last pap smear	_____	

Respiratory

Chronic/frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma/wheezing	No	Yes

Integumentary (Skin, Breast)

Rash or Itching	No	Yes
Change in skin color	No	Yes
Change in hair/nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

Hematological/Lymphatic

Slow to heal after cuts	No	Yes
Bleeding/bruising tendency	No	Yes
Anemia or past transfusion	No	Yes
Phlebitis	No	Yes
Swollen gland	No	Yes
HIV	No	Yes
Hepatitis	No	Yes

Allergic/Immunologic

LATEX ALLERGY	No	Yes
Food allergies	No	Yes
_____		
Environmental allergies	No	Yes
_____		

Social History

Marital Status ____ Children_____ Ages_____

Occupation _____

Tobacco _____ No Yes

Alcohol drinks per week=_____ IV Drugs No Yes

Reviewed By: _____Date_____

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Patient Signature_____