#### Marin Cancer Care

1350 South Eliseo Drive, Greenbrae, CA 94904-2018

Medical Oncology & Hematology Radiation Oncology

Suite 200 (415) 925-5000 Fax: (415) 925-5050 Suite 100 (415) 925-7326 Fax: (415) 925-7333

#### **HEALTH HISTORY INFORMATION**

Information in this confidential record will not be released unless you have authorized us to do so. Your history is very important to us. Please take the time to complete this accurately and fully.

Name		Preferred Name
Birthdate	Age	
Address		
		Zip
Home Phone	Work	Phone
Cell Phone	Email	Address
Preferred Method of Contact:		
		Spoken Language
Employer	Оссиј	pation
Emergency Contact:		
Name	Address	
Relationship	Phone	Email
Name	Address	
Relationship	Phone	Email
Referring Physician		
Medicare #:		Medi-Cal #:
INSURANCE (primary)		Plan
		Plan
Company, or its representative understand that I am financiall A Medical Group, Inc.	e, any information reg y responsible for the	roup, Inc., to release to my insurance parding medical care rendered to me. I medical care rendered to me by Marin Cancer Care
Authorization for Release of In	formation, Medical R	ecords, X-rays, etc., FROM:
Patient's Signature		Date

				NAME	
I. ALLERGIES Are you allergic to any medicine? If yes, please list name:			□ No your reac	☐ Yes ction: (e.g., rash, shortn	ness of breath)
		_ _ _			
Have you any other			$\square$ No	□ Yes	
If yes, please provide Pacemaker?	le details □ <b>No</b>	□ Yes	If yes, please ε	attach copy of device I	D card
II. MEDICATIONS Please list all medications - prescri MEDICATION/SUPPLEMENTS VITAMINS			non-prescription  DOSE	HOW OFTEN	DURATION
				·	
				·	
Your Pharmacy				Phone Number (	)

<b>NAME</b>	

#### III. PAST MEDICAL HISTORY Please check any of the following you have had and indicate the date of onset next to the item: Anemia **Diabetes** Kidney Stone Liver Disease Asthma Elevated Cholesterol Autoimmune Disease Gallbladder Disease Pneumonia Prostate Trouble **Blood Clots** Glaucoma **Blood Disease Heart Disease** Psychiatric Diagnosis Cancer Hepatitis B Sleep Apnea Hepatitis C Abnormal TB Skin Test Cataracts Colitis Herpes Zoster(shingles) Thyroid Disease COPD/Emphysema High Blood Pressure **Ulcer Disease** Depression/Anxiety Kidney Disease Other **HOSPITALIZATIONS** Have you ever been hospitalized? $\square$ No □ Yes If yes, please indicate reason for hospitalization Date Please tell us when you last had a: Date: \_\_\_\_\_ 1) Stool test for blood: 2) Sigmoidoscopy or colonoscopy: (circle which) Date: \_\_\_\_\_ 3) Pneumonia shot Date: \_\_\_\_\_ 4) Shingles shot Date: \_\_\_\_\_ Women: 1) Pap Smear: Date: \_\_\_\_\_ 2) Mammogram: Date: \_\_\_\_\_

Men:

1) Prostatic Specific Antigen:

NAME

# **WOMEN** Age at first Period? \_\_\_\_\_ Age at Menopause? \_\_\_\_\_ ☐ Painful ☐ Abnormal Bleeding ☐ Discharge Menses: $\Box$ Irregular $\Box$ Heavy Date of last Menses \_\_\_\_\_ Date of last Pap Smear \_\_\_\_\_\_ Result: \[ \subseteq \text{Normal} \subseteq \text{Abnormal} \] Number of: Pregnancies \_\_\_\_\_ Deliveries \_\_\_\_ Therapeutic Abortions \_\_\_\_ Miscarriages \_\_\_\_ Complications Age at first term pregnancy?\_\_\_\_\_ Did you breast feed? No Yes Total Length? \_\_\_\_\_ Birth Control Pills? $\Box$ No $\Box$ Yes If yes, for how long?\_\_\_\_\_ when did you last take them?\_\_\_\_ Have you ever taken hormone replacement? $\square$ No □ Yes If yes, what?\_\_\_\_\_ for how long? \_\_\_\_ Have you ever taken fertility drugs? $\square$ No □ Yes If yes, what? \_\_\_\_\_ when? \_\_\_\_ How would you rate your general health? $\Box$ Excellent $\Box$ Good $\Box$ Fair $\Box$ Poor Has any medical or surgical treatment ever been recommended and not performed? $\Box$ No $\Box$ Yes If yes, what? Toxic Exposure? $\square$ No $\square$ Yes If yes, what? IV. RADIATION THERAPY **Have you ever had radiation therapy?** $\Box$ No $\Box$ Yes V. SURGERIES Have you ever had surgery? $\square$ No □ Yes If yes, please indicate type of operation Date

NAME		
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## VI. BLOOD TRANSFUSIONS AND DONATIONS

Have you ever had a blood transfusion?  If yes, when and why?	□ No	□ Yes
any reaction?		
Have you ever donated blood?	□ No	□ Yes, <i>year</i>
VII. HABITS		
Do you drink alcoholic beverages? ☐ No ☐ Yes	If no, have ye	ou in the past?
How many drinks per day	or drinks per	week
Have you ever smoked cigarettes?	$\square$ No	□ Yes
How many packs per day?	_ For how man	ny years?
How old were you when you started?	_	
Are you currently smoking?  If you quit, when did you quit?	□ No _	□ Yes
Have you ever chewed tobacco?	$\square$ No	□ Yes
Do you use medical marijuana?	$\square$ No	□ Yes
Have you used recreational drugs?	$\square$ No	□ Yes
Do you exercise?  If yes, what type and how often?	□ No	□ Yes
What do you enjoy doing?		

#### VIII. FAMILY HISTORY

		IF LIVING			CEASED	
	Name	Age	Health		Age	Cause
Mother						
Father						
Sister Brother						
Sister Brother						
Sister Brother						
Sister Brother						

		NAME				
Spouse/Companion						
Son Daughter						
Son Daughter						
Son Daughter						
Son Daughter						
Son Daughter						
	Please list all 1	relatives with history of co	ancer			
RELATIVE TYPE OF CANCER AGE at diagnosis If deceased, AGE at d						
IX. SOCIAL HISTO		Marital Status □ M	□ D □ W □ Never Married			
How many people live W	e in your home now? ho besides yourself?					
Highest Grade Comple	eted					
Current Occupation _						
Previous Occupations						
We'd like to know as a questions. Circle the n during your visit.	much as possible about you umber which best describes	r current state of health, so s your symptoms. The nur	o please answer the following se or doctor will discuss these with			

# **DISTRESS** (please circle one)

Some patients experience fears, worries, and sadness which all tend to increase their level of distress.

0	1	2	3	4	5	6	7	8	9	10
None	Moderate						Е	Extreme		

The main source of my distress is:

## PAIN (please circle one)

						NA	ME _			·
- 701-		4	-£: - I 1	1 1	: 41	41				
a. The	e <u>averag</u> e	_ 	-	nave nad	in the pas	t week:			ı	
Nama	1	2	3	4	Ma danata	6	,	7 8	9	
None					Moderate					Extreme
b. Th	e <u>most</u> p	ain I have	had in th	e last wo	eek:					
0	1	2	3	4	5	6	,	7 8	9	10
None					Moderate					Extreme
Where do	you have	pain?								
	-		)							
FATIGUI	t (piease	e circle or	ie)							
	he <b>past w</b>									
a. My	/ ratigue i	level has t	been:							
0	1	2	3	4	5	6	,	7 8	9	10
None		•			Moderate			·		Severe
h Do	es vour f	atione inte	erfere in v	our activ	vities of da	ily livino	σ?			
<i>0.</i> <b>D</b> 0	·		critere in y	_	vities of da	ily ilvilig	5•			
		Yes	L	_ No						
In the pas	t few day	ys, I woul	d best de	scribe m	ny activity	level as	(plea	se check o	ne):	
I am a I can p I can c	ble to car perform n care for m	ry on nor ormal act nyself, but	mal activi ivities wit am unabl	ty; mino h effort; le to carr	of disease or signs or s I note som y on norm to care for	symptom ne signs o al activit	or syn	nptoms of lo active w		
X. REVIE				anv prob	doms with					
HEAD []		nave rece	тиу паа с	ту ргоо	tems wim.					
	Traum	a		Head	dache					
EYES   I	None Glasse Contac Pain			Tear	Eyes ring nmering Sp	oots		Color Blii Vision: B Blind Spo	lurred/Do	
EARS []	None									
	Pain			Disch	arge			Hearing I	Problems	
	Ringin	ıg		Infect				Hearing A		
MOUT <u>H</u>	□ None		_	_						

Ulcers/cold sores

Change in Taste

Pain

	1	AME	
<ul><li>Dentures</li><li>Partial Plates</li></ul>	<ul><li>Dry Mouth</li><li>Tongue: Sore, Enlar</li></ul>	Periodontal Dise	ase
NOSE & THROAT □ None			
Hoarseness Nose Bleeds	Change in Smell/Vo Nasal Obstruction	ce Sinus Problems	
<b>RESPIRATORY</b> □ None			
Chest Pain	Fever	Coughing Blood	l
Chills  Desitive TD Strip To	Shortness of Breath	Wheezing	V mary
Positive TB Skin Ter Cough Sputum; Colo	&	Abnormal Ches	. Х-гау
<b>CARDIOVASCULAR</b> □ None			
Angina		Pain: Jaw, Neck	, Chest, Mid-Back
Abnormal Cardiogra	m (EKG)	Leg Cramps	D11.1.1.1
Shortness of Breath		Varicose Veins of Swollen Feet or	
Rapid Heart Beat Irregular Heart Beat	(Palnitations)	Swollen reet of	Alikies
Inegalai Heait Beat	(Turpitutions)		
$\textbf{GASTROINTESTINAL} \ \ \square \ \text{Non}$	e	_	
Poor Appetite	Abdominal Pain	Food Intolerance	or Allergy
Nausea Die	Vomiting	☐ Vomiting Blood	
Diarrhea  Departs   Planting	Laxative Use	Belching  Change in Steel	G:
Rectal Bleeding Jaundice	☐ Bloating ☐ Constipation	Change in Stool Black, White, Bl	
Heartburn	Trouble Chewing	Hemorrhoids	oody Stool
Trouble Swallowing		<b>—</b>	
MUSCULOSKELETAL   Non			
Bone Pain  Loint: Stiffness Swe	☐ Muscle Pain	Back Pain	
Joint: Stiffness, Swe	lling, Pain or Redness; which	one(s):	<del></del>
<b>SKIN</b> □ None			
Rash	Dryness	Sore which does	not heal
Itch	Burning	Biopsy or Remo	val of Lesion
Change in: Birthmar	ks, Hair, Nails, moles		
<b>HEMATOLOGICAL</b> □ None			
Easy Bruising or Ble	eeding Swol	en Lymph Nodes: Neck, (	Groin, Under Arms
		,	,
NEUROLOGICAL & PSYCHO		□ <b>.</b>	
Fainting	Dizziness	Loneliness	
Tingling Personality Change	Numbness Nervousness	Depression Worry	
Personality Change Incoordination	☐ Nervousness ☐ Paralysis	Worry Weakness	
Unconsciousness	Irritability	Thick Speech	
Suicidal Thoughts	Seizures	Convulsions	

INA	AME			 
<ul><li>Daydreaming</li><li>Loss of Temper</li><li>Difficulty Walking in the Dark</li></ul>	I	Fatigue		
ENDOCRINE & METABOLISM ☐ None ☐ Poor Energy ☐ Increased Thirst Feel: ☐ Too hot / ☐ Too Cold  Recent Weight Change: ☐ None ☐ Loss / ☐ Gain Present Weight:lbs. Usual Weight	of		ls since	
GENITOURINARY	es	ing or Sto	opping	
SEXUALITY  Are you sexually active?	f cancer		es atments?	 
XI. YOUR TREATMENT				
Have you ever had to cope with a major illness of your own or a person close to you?		No	Yes	
Do you know anyone who has received treatment for cancer including radiation or chemotherapy?		No	Yes	
Have you known anyone with an illness similar to yours?		No	Yes	
Have you ever seen a therapist or counselor?		No	Yes	
Would you be interested in: Individual supportive counseling during your treatment? Participating in a support group to discuss mutual concerns		No	☐ Yes	Maybe
Participating in a support group to discuss mutual concerns, feelings, etc.?		No	Yes	Maybe
Counseling for family members to assist them in coping with your illness?		No	Yes	Maybe
Have you ever used relaxation techniques (such as hypnosis or bio-feedback)?		No	Yes	
Would you like to know about Guided Imagery, Visualization, and Relaxation Training?		No	Yes	Maybe
What complementary or alternative therapies are you using?				

Do you have a durable power of attorney for health care?  If you have, please provide us with a copy for your reco	No ord.	Yes
Do you have an advance directive?  If you have, please provide us with a copy for your reco	☐ No ord.	Yes
Some people wish to know as much as they can about their illn care. Others wish to know the basics and want their doctors to		
What questions do you have regarding treatment?		
Would you like information on:		
☐ Resources for educational materials in the hospital's CIRCI	LE library (vide	os, audio materials, etc.)
$\hfill \Box$ Community resources, i.e., how to find help at home (house	ekeeping, meal p	preparation, etc.),
transportation, attendant/nursing care, etc.		
☐ Financial resources, programs, etc.		
How can we help you?		
Patient Health History dictated by:		Date:

NAME \_\_\_\_\_