Marin Cancer Care

1350 South Eliseo Drive, Greenbrae, CA 94904-2018

Medical Oncology & Hematology — Suite 200 (415) 925-5000 Fax: (415) 925-5050
Radiation Oncology — 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 _____

City/State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Preferred Method of Contact: _____

Gender _____ Race _____ Ethnicity _____ Spoken Language_____

Employer _____ Occupation _____

Emergency Contact:

Name _____ Address _____

Relationship _____ Phone _____ Email _____

Name _____ Address _____

Relationship _____ Phone _____ Email _____

Referring Physician _____

Other Physicians _____

_____

Medicare #: _____ Medi-Cal #: _____

INSURANCE **(primary)** _____ Plan _____

INSURANCE **(secondary)**_____ Plan _____

I hereby authorize Marin Cancer Care, A Medical Group, Inc., to release to my insurance Company, or its representative, any information regarding medical care rendered to me. I understand that I am financially responsible for the medical care rendered to me by Marin Cancer Care, A Medical Group, Inc.

Authorization for Release of Information, Medical Records, X-rays, etc., FROM:

_____

Patient's Signature _____Date_____

NAME _____

I. ALLERGIES

Are you allergic to any medicine? ☐ No ☐ Yes

If yes, please list name: *your reaction:* (e.g., rash, shortness of breath)

_____ _____

_____ _____

_____ _____

_____ _____

Do you have any other allergies? ☐ No ☐ Yes

If yes, please provide details _____

Pacemaker? ☐ **No** ☐ **Yes** **If yes, please provide a copy of device ID card**

II. MEDICATIONS

Please list all medications - prescription and non-prescription

MEDICATION/SUPPLEMENTS VITAMINS	DOSE	HOW OFTEN	DURATION

Your Pharmacy	Phone Number

NAME _____

III. PAST MEDICAL HISTORY

Please check any of the following you have had and year of onset:

☐ Anemia	☐ Diabetes	☐ Kidney Stone
☐ Asthma	☐ Elevated Cholesterol	☐ Liver Disease
☐ Autoimmune Disease	☐ Gallbladder Disease	☐ Pneumonia
☐ Blood Clots	☐ Glaucoma	☐ Prostate Trouble
☐ Blood Disease	☐ Heart Disease	☐ Psychiatric Diagnosis
☐ Cancer	☐ Hepatitis B	☐ Sleep Apnea
☐ Cataracts	☐ Hepatitis C	☐ Abnormal TB Skin Test
☐ Colitis	☐ Herpes Zoster(shingles)	☐ Thyroid Disease
☐ COPD/Emphysema	☐ High Blood Pressure	☐ Ulcer Disease
☐ Depression/Anxiety	☐ Kidney Disease	☐ *Other*

_____
_____
_____

HOSPITALIZATIONS (excluding surgeries)

Have you ever been hospitalized? ☐ No ☐ Yes

If yes, please indicate reason for hospitalization *Date*

_____ _____
_____ _____

Please tell us when you last had a:

1) Stool test for blood: Date: _____
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: Date: _____

NAME _____

WOMEN

Age at first Period? _____ Age at Menopause? _____

Menses: ☐ Irregular ☐ Heavy ☐ Painful ☐ Abnormal Bleeding ☐ Discharge

Date of last Menses _____

Date of last Pap Smear _____ *Result*: ☐ Normal ☐ 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? ☐ No ☐ Yes

*If yes, for how long?*_____ *when did you last take them?*_____

Breast: ☐ Lump ☐ Discharge ☐ Pain ☐ Swelling

Have you ever taken hormone replacement? ☐ No ☐ Yes

*If yes, what?*_____ *for how long?* _____

Have you ever taken fertility drugs? ☐ No ☐ Yes

If yes, what? _____ w*hen?* _____

Are you currently pregnant or trying to get pregnant? ☐ No ☐ Yes

Could you be pregnant? ☐ No ☐ Yes

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has any medical or surgical treatment ever been recommended and not performed? ☐ No ☐ Yes

If yes, what? _____

Toxic Exposure? ☐ No ☐ Yes

If yes, what? _____

IV. RADIATION THERAPY

Have you ever had radiation therapy? ☐ No ☐ Yes

V. SURGERIES

Have you ever had surgery? ☐ No ☐ Yes

If yes, please indicate type of operation *Date*

_____ _____

_____ _____

_____ _____

NAME _____

VI. BLOOD TRANSFUSIONS AND DONATIONS

Have you ever had a blood transfusion? ☐ No ☐ Yes
If yes, when and why? _____

any reaction? _____

Have you ever donated blood? ☐ No ☐ Yes, *year* _____

VII. HABITS

Do you drink alcoholic beverages? ☐ No ☐ Yes If no, have you in the past? _____

How many drinks per day _____ or drinks per week _____

Have you ever smoked cigarettes? ☐ No ☐ Yes

How many packs per day? _____ For how many years? _____

How old were you when you started? _____

Are you currently smoking? ☐ No ☐ Yes
If you quit, when did you quit? _____

Have you ever chewed tobacco? ☐ No ☐ Yes

Do you use medical marijuana? ☐ No ☐ Yes

Have you used recreational drugs? ☐ No ☐ Yes

Do you exercise? ☐ No ☐ Yes
If yes, what type and how often? _____
_____

What do you enjoy doing? _____

VIII. FAMILY HISTORY

		IF LIVING			IF DECEASED	
	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 relatives with history of cancer

RELATIVE	**TYPE OF CANCER**	**AGE at diagnosis**	**If deceased, AGE at death**

IX. SOCIAL HISTORY

Where were you born? _____

How many people live in your home now? _____ ☐ M ☐ D ☐ W ☐ Never Married

Who besides yourself? _____

Highest Grade Completed _____

Current Occupation _____

Previous Occupations _____

We'd like to know as much as possible about your current state of health, so please answer the following questions. Circle the number which best describes your symptoms. The nurse or doctor will discuss these with you during your visit.

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					Extreme

The main source of my distress is: _____

NAME _____

PAIN (please circle one)

a. The **<u>average</u>** amount of pain I have had in the **past week**:

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

b. The **<u>most</u>** pain I have had in the **last week**:

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

Where do you have pain? _____

FATIGUE (please circle one)

Over the **past week:**

a. My fatigue level has been:

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

b. Does your fatigue interfere in your activities of daily living?

☐ Yes ☐ No

In the past few days, I would best describe my activity level as (please check one):

☐ I feel normal; no complaints; no symptoms of disease.
☐ I am able to carry on normal activity; minor signs or symptoms of disease.
☐ I can perform normal activities with effort; I note some signs or symptoms of disease.
☐ I can care for myself, but am unable to carry on normal activity or do active work.
☐ I require occasional assistance but am able to care for most of my own need

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X. REVIEW OF SYSTEMS

Please check if you have recently had any problems with:

HEAD ☐None

☐Trauma ☐Headache

EYES ☐None

☐Glasses ☐Dry Eyes ☐Color Blindness
☐Contacts ☐Tearing ☐Vision: Blurred/Double
☐Pain ☐Shimmering Spots ☐Blind Spots, Blindness

EARS ☐None

☐Pain ☐Discharge ☐Hearing Problems
☐Ringing ☐Infections ☐Hearing Aid

NAME _____

MOUTH ☐ None

☐ Pain ☐ Ulcers/cold sores ☐ Change in Taste
☐ Dentures ☐ Dry Mouth ☐ Periodontal Disease
☐ Partial Plates ☐ Tongue: Sore, Enlarged ☐ Teeth Problems

NOSE & THROAT ☐ None

☐ Hoarseness ☐ Change in Smell/Voice ☐ Sinus Problems
☐ Nose Bleeds ☐ Nasal Obstruction

RESPIRATORY ☐ None

☐ Chest Pain ☐ Fever ☐ Coughing Blood
☐ Chills ☐ Shortness of Breath ☐ Wheezing
☐ Positive TB Skin Test ☐ Night Sweats ☐ Abnormal Chest X-ray
☐ Cough Sputum; Color: _____

CARDIOVASCULAR ☐ None

☐ Angina ☐ Shortness of breath
☐ Abnormal Cardiogram (EKG) ☐ Leg Cramps
☐ Pain: Jaw, Neck, Chest, Mid-Back ☐ Varicose Veins or Phlebitis
☐ Rapid Heart Beat ☐ Swollen Feet or Ankles
☐ Irregular Heart Beat (Palpitations)

GASTROINTESTINAL ☐ None

☐ Poor Appetite ☐ Abdominal Pain ☐ Food Intolerance or Allergy
☐ Nausea ☐ Vomiting ☐ Vomiting Blood
☐ Diarrhea ☐ Laxative Use ☐ Belching
☐ Rectal Bleeding ☐ Bloating ☐ Change in Stool Size
☐ Jaundice ☐ Constipation ☐ Black, White, Bloody Stool
☐ Heartburn ☐ Trouble Chewing ☐ Hemorrhoids
☐ Trouble Swallowing ☐ Gallbladder Problems

MUSCULOSKELETAL ☐ None

☐ Bone Pain ☐ Muscle Pain ☐ Back Pain
☐ Joint: Stiffness, Swelling, Pain or Redness; which joint(s): _____

SKIN ☐ None

☐ Rash ☐ Dryness ☐ Sore that does not heal
☐ Itch ☐ Burning ☐ Biopsy or Removal of Lesion
☐ Change in: Birthmarks, Hair, Nails, Moles

NAME _____

HEMATOLOGICAL ☐ None

☐ Easy Bruising or Bleeding ☐ Swollen Lymph Nodes: Neck, Groin, Under Arms

NEUROLOGICAL & PSYCHOLOGICAL ☐ None

☐ Fainting	☐ Dizziness	☐ Loneliness
☐ Tingling	☐ Numbness	☐ Depression
☐ Personality Change	☐ Nervousness	☐ Worry
☐ Incoordination	☐ Paralysis	☐ Weakness
☐ Unconsciousness	☐ Irritability	☐ Thick Speech
☐ Suicidal Thoughts	☐ Seizures	☐ Convulsions
☐ Daydreaming	☐ Loss of Temper	☐ Fatigue
☐ Difficulty Walking in the Dark		

ENDOCRINE & METABOLISM ☐ None

☐ Poor Energy ☐ Increased Thirst ☐ Appetite Change

Feel: ☐ Too Hot ☐ Too Cold

Recent Weight Change : ☐ None ☐ Loss ☐ Gain of _____ pounds since _____

Present Weight: _____lbs. Usual Weight _____lbs. Greatest Weight _____lb

GENITOURINARY ☐ None

☐ Pain with Urination or Intercourse
☐ Urinate Frequently During the Day: _____ times
☐ Urinate Frequently During the Night: _____ times
☐ Urine Stream: Weaker, Smaller, Dribbling, Difficulty Starting or Stopping
☐ Incontinence
☐ Dark or Red Urine

SEXUALITY

Are you sexually active? ☐ No ☐ Yes

Are you having any problems with sexuality as a result of cancer or its treatments?

_____

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

NAME _____

Would you be interested in:

Individual supportive counseling during your treatment? ☐ 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? ☐ No ☐ Yes
If yes, please provide us with a copy for your record.

Do you have an advance directive? ☐ No ☐ Yes
If yes, please provide us with a copy for your record.

Some people wish to know as much as they can about their illness and to make their own decisions about their care. Others wish to know the basics and want their doctors to make the appropriate choice. How do you feel?

_____

_____

What questions do you have regarding treatment? _____

_____

Would you like information on:

Resources for educational materials in the hospital's CIRCLE library (videos, audio materials, etc.)

Community resources, such as how to find help at home (housekeeping, meal preparation, etc.), transportation, attendant/nursing care, etc.

Financial resources, programs, etc.

How can we help you? _____

_____