

## Montana Cancer Center

Patient Name:		Age:Date of Birth:
	ng Providers:	
		Radiation Oncologist:
Other Providers See	n:	Dentist:
<b>Pharmacy</b> Choice ar	nd Location:	
Reason for Visit:		
Madiaatiana Vitam	ing and Cumplements Diagon list or attach	a complete list of all current
<u> Medications, Vitam</u>	ins, and Supplements Please list or attach	a complete list of all current.
Allergies/Reactions	Please list all allergies and specific reaction	ons:
□ Penicillin	What happens?	
□ Codeine	What happens?	_
□ Sulfa	What happens?	_
□ Aspirin	What happens?	_
□ lodine	What happens?	_
□ X-ray contrast	What happens?	_
□ Food	What happens?	_
□ Other	What happens?	
		_
Personal Medical/S	urgical History:	
Please list all of you	r past and current medical problems:	
	<u> </u>	
Please list all of you	r past surgeries:	
Please list all of you	r past injuries:	

Date completed/revised:

Version: 2/2018 PATIENT LABEL

Have you eve	r had any of the followi	<b>ng</b> : Facility Loca	tion Dates	5	Doctor		
Biopsies:			/		,		
	y:				/		
Radiation The	rapy:		/		<i>J</i>		
Hormones:			/		<i>J</i>		
<b>Health Maint</b>	enance:						
Date of last:	Influenza Vaccine:		Pneum	nonia Vaccine:			
	Shingles Vaccine:		Chest	X-Ray:			
Female:				Male:			
Date of last m	ammogram:		Date o	f last PSA:			
Date of last colonoscopy:  Date of last bone density:  Date of last PAP smear:				ast prostate/re	ctal exam:		
Date of last DAD smear:				Date of last colonoscopy:			
Date of last PA	AP smear:						
Family History	<b>⊻</b> : Living/Dead	Age/Age at De	ath Preser	nt Health/Cause	e of Death		
Father							
Mother							
Spouse							
Brothers	Number Living		Health	l			
	Number Dead		Cause	of Death			
Sisters	Number Living		Health				
	Number Dead		Cause	of Death			
Children	Number Living		Health				
	Number Dead		Cause	of Death			
<b>Social History</b>	:						
Are you:	Single Married	Separated	Divorced	Widowed	Domestic Partnership		
Do you live ald	one? Y	N					
Do you live alone? Y N  Do you have any children? Y N Ho		How many? _		Ages:			
Who lives in your home? Do you				Part Time	Full Time		
Past or preser	nt occupation:						
Education (lev	vel completed)						

Habits:	Smoked		Chewed Tobacco			Drank Alcohol			Marijuana/Drugs		
Do you or have you ever:	Υ	N	Y	N N	acco	Y	N		Y	N	
How many years?											
Do you still:	Υ	N	Y	N		Y	N		Y	N	
If you quit, when:											
How much per day:											
What type:											
Have you ever been told/aske	ed to st	op?		Υ	N						
Have you been in a screening		. •	quit?	Υ	N						
Are you interested in a progra	am to q	uit?		Υ	N						
Constitutional/General Revie	<u>:w:</u>										
Fatigue: Y N		Fevers: Y	N			Nigh	t Sweats:	Υ	N		
Are you Claustrophobic: Y	N										
Weight Change: Y N Gained? Los Are you eating less because o	t?f a dec	How many poun	Υ	N							
		oes it hurt? lps?									
		:he level (1-10) ge									
v	viiat is	.iie ievei (1-10) ge	riciany	·	_ vviiat ii	everati	. 3 WOI3t:				
Do you feel safe at home?:	Υ	N									
In the past month, have you	vished	ou were dead or	wished	d you co	uld go to	sleep a	nd not wak	e up?	Υ	N	
In the past month, have you a	ctually	had any thoughts	s of killi	ng your	self? Y	N					
Do you have difficulty reading	ς? Υ	N									
Do you drive? Y N		Do yo	u have	any driv	ing prob	olems?	Υ	N			
Please list any implanted dev	ces, pa	cemaker or metal	l in you	r body:							
Do you have an Advanced Dir	ective,	Durable Power of	Attorn	ney for H	ealthcar	e, Living	Will? Y		N		
Do you have a POLST? Y	N										
Is there anyone you do NOT v	vish us	to share your hea	lthcare	informa	ation wit	h? Y	N				
If ves_nlease list name(s) and	relatio	nshin to you:									

## **Review of Systems:**

1	Eyes/Ears/Nose/Throat/Mout	h		6	Urinary		
	Problems with eyes?	Υ	N		Loss of urine	Υ	Ν
What:Problems with ears?					Frequent urination	Υ	Ν
		Υ	N		Nighttime urination	Υ	Ν
	What:	_			How frequent?		
	Problems with nose?	Υ	N		Blood in urine	Υ	Ν
	What:	_			Burning/painful urination	Υ	Ν
	Problems with throat/mouth?	Υ	N		Kidney disease/insufficiency	Υ	Ν
	What:				Sexually active	Υ	Ν
2 Neurological				7	Hematologic/Immune		
	Convulsions/Seizures	Υ	N		Bleeding tendency	Υ	Ν
	Stroke/ Headaches	Υ	N		Anemia	Υ	Ν
	Epilepsy	Υ	N		Enlarged lymph nodes	Υ	Ν
3	Cardiovascular				Blood Transfusion?	Υ	Ν
	High blood pressure Y N		N				
	Heart Attack	Υ	N	8	Musculoskeletal		
	Murmur	Υ	N		Muscle/Joint problems	Υ	Ν
	Chest pains, angina	Υ	N		Bone problems	Υ	Ν
	Heart disease	Υ	N		Swelling	Υ	Ν
	Fainting		N	9	Skin		
4	Respiratory				Skin Cancer	Υ	Ν
	Bronchitis	Υ	N		Other skin problems	Υ	Ν
	Emphysema	Υ	N	10	Psychiatric		
	Asthma	Υ	N		Psychiatric therapy	Υ	Ν
	Abnormal chest x-ray	Υ	N		Psychiatric diagnosis	У	Ν
	Cough	Υ	N	11	Endocrine		
	Coughing up blood	Υ	N		Diabetes	Υ	Ν
	Difficulty breathing	Υ	N		Thyroid disease	Υ	Ν
	Chest pain	Υ	N		Hormonal problem	Υ	Ν
	Wheezing	Υ	N	12	Genital- Female		
5	Gastrointestinal				Vaginal Bleeding	Υ	Ν
	Difficulty swallowing	Υ	N		Vaginal discharge	Υ	Ν
	Stomach problems	У	N		Do you menstruate?	Υ	Ν
	Abdominal pain	Υ	N		Irregular periods	Υ	Ν
	Nausea	Υ	N		Painful periods	Υ	Ν
	Vomiting	Υ	N		Painful intercourse	Υ	Ν
	Vomiting blood	Υ	N		# of pregnancies # of of	deliverie	s
	Change in bowel habits	Υ	N		Date of last period		
	Constipation	Υ	N		Birth Control Pills or Hormon	es Y	Ν
	Diarrhea	Υ	N		How longPill name		
	Blood in stools	Υ	N		Any chance you are pregnant Y		
	Jaundice, hepatitis	Υ	N		Method of Birth Control		
	Liver Disease	Υ	N		ΡΔΤΙΕΝΤ Ι ΔΒΕΙ		

PATIENT LABEL