ALLIANCE CANCER CENTER
Exceptional care. Close to home.

Initial Patient History Questionnaire

Patient Name: _____

Medical Record #: _____

Date of Birth: _____

Date_____

Allergies: ☐ NONE ☐ Shellfish ☐ Iodine ☐ Latex ☐Penicillin ☐ Sulfa ☐ Other: _____

Primary Language: _____

Other Language: _____

Last grade completed: _____

How do you like to learn?

☐Hear/Verbal ☐Video ☐Demonstration ☐Read

Who referred you to our facility?

☐ Your Doctor ☐ Yourself ☐Radio ☐Billboard ☐Internet ☐Ad ☐ News story ☐ Friend/Family ☐Have been here before as a patient

Where did you first hear about our facility?

☐ Your Doctor ☐Radio ☐Billboard ☐Internet ☐Ad ☐ News story

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow

Occupation: _____

Who is available to help you if you need it? _____

_____

Do you smoke?

☐ **No** Did you quit? ☐Yes When? _____

How many packs did you smoke/day _____

For how many years? _____

☐ **Yes** How many packs/day? _____For how many years? _____

Do you drink alcohol? ☐ No ☐ In recovery ☐ Yes How often? _____

Do you take drugs other than those from a doctor?

☐ No ☐ Yes, _____

Do you _____live alone? _____with family? _____other?

Do you drive? ☐ No ☐ Yes

Are you receiving home care services? ☐ Nurse ☐ Therapy ☐ Hospice

How do you feel about being here today?

☐ Angry ☐Anxious ☐Concerned ☐Helpless ☐Hopeless ☐Depressed ☐Scared ☐ Positive ☐ Supported ☐Isolated ☐ Overwhelmed ☐Hopeful ☐ Relieved ☐ Other: _____

Do you have an Advanced Medical Directive/Living Will or Power of Attorney? ☐ No ☐ Yes - Please give us a copy for your chart

Would you like a referral to a social worker? ☐ No ☐ Yes

Would you like a referral to a dietitian? ☐ No ☐ Yes

Would you like a referral for spiritual needs? ☐ No ☐ Yes

Do you have any religious/cultural/spiritual beliefs we should be aware of to better care for you?

☐ No

☐ Yes, Please describe: _____

How is your appetite? ☐Good ☐Fair ☐Poor

Have you lost weight in the last 6 months? ☐ No ☐Yes How many pounds? _____

On purpose? ☐No ☐Yes

Please indicate yes/no to the following:	Yes	No
Heart Disease (Heart attack, angina, CHF)		
Pacemaker/Defibrillator		
Stroke		
Diabetes (sugar problems)		
Hypertension (high blood pressure)		
Emphysema		
Tuberculosis		
Pneumonia		
Peptic Ulcer		
Bowel Problems		
Hepatitis		
Urinary Problems (kidney/bladder)		
History of sexual or physical trauma		
Do you feel safe in your home?		
Are you/could you be pregnant?		
Gynecologic problems (infections, etc.)		
Depression or mental illness		
Have you ever attempted suicide?		
History of substance abuse		
Thyroid problems		
Seizures		
Personal History of Cancer		
Previous Chemotherapy		
Previous Radiation Therapy (if yes, please list areas of body treated):		
List Hospital/Facility where treated:		
Please list any previous surgeries:		
Family history of cancer (if yes, please list):		

Patient signature:

_____

Date: _____

Staff Only:

Reviewed by:

_____

Date: _____