CALIFORNIA CANCER CARE

CALIFORNIA CANCER CARE, INC.
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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 fully and accurately.

Name _____ Birthdate ____/____/____

Soc. Sec. No. ____-____-____ City Born _____

Address _____

City/State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Preferred Contact Method (example: Cell Phone) _____

Gender _____ Language _____

Race: Please update Race (check all that apply)

☐ Caucasian ☐ African American ☐ American Indian ☐ Asian ☐ Chinese ☐ Filipino
☐ Japanese ☐ Korean ☐ Vietnamese ☐ Pacific Islander ☐ Middle Eastern
☐ Other Asian _____ ☐ Other _____ ☐ Decline to State

Ethnicity: Please update Ethnicity (check one)

☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Decline to State

Marital Status _____ Occupation _____

Spouse's Name _____ Spouse's Work Phone _____

Friend or Family Member's Name _____

Relationship _____ Phone _____

Referring Physician _____

Other Physicians _____

Medicare #: _____ Medi-Cal #: _____

INSURANCE **(primary)** _____ Group # _____

Effective Date: _____

Co-Pay _____ Deductible _____

INSURANCE **(secondary)** _____ Group # _____

Effective Date: _____

Co-Pay _____ Deductible _____

I hereby authorize California 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 California Cancer Care, A Medical Group, Inc.

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

I give my consent to allow California Cancer Care to obtain my electronic prescription history. ☐ Yes ☐ No

Patient's Signature _____ Date _____

PHARMACY

Your Local Pharmacy_____ **Phone Number ( )**_____

Address_____

Your Mail Order Pharmacy_____ **Phone Number ( )**_____

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 you any other allergies? ☐ No ☐ Yes

If yes, please provide details _____

MEDICATIONS

Please list all medications, prescription and non-prescription, that you have taken in the last two weeks:

MEDICATION	DOSE	HOW OFTEN	FOR HOW LONG

PAST MEDICAL HISTORY

Please check any of the following you have had and indicate the date of onset next to the item:

☐ Abnormal heart rhythm	☐ Gallbladder disease	☐ Pancreatitis
☐ Atrial fibrillation	☐ GERD	☐ Parasites
☐ Anemia	☐ Glaucoma	☐ Parkinson's
☐ Angina/chest pain	☐ Gout	☐ Pleurisy
☐ Arthritis	☐ Heart attack/disease	☐ Pneumonia
☐ Asthma	☐ Heart murmur	☐ Prostate trouble
☐ Bleeding tendency	☐ Hepatitis/liver disease	☐ Psoriasis
☐ Blood clots	☐ Herpes	☐ Skin cancer
☐ Blood disease	☐ Herpes Zoster (Shingles)	☐ Stomach aches
☐ Cancer	☐ High blood pressure	☐ Stroke/TIA
☐ Cirrhosis of liver	☐ HIV	☐ Abnormal TB skin test
☐ Colitis	☐ Irritable bowel	☐ Thyroid disease
☐ Depression	☐ Kidney disease	☐ Tremors
☐ Diabetes	☐ Kidney stones	☐ Tuberculosis
☐ Eczema	☐ Meningitis	☐ Ulcer disease
☐ Emotional problems	☐ Mononucleosis	☐ Vein problems
☐ Emphysema/COPD	☐ Neuropathy	☐ Venereal disease
☐ Frequent infections	☐ Pacemaker	☐ *Other* _____

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

Are you aware of any toxic substance you might have been exposed to? ☐ No ☐ Yes
If yes, please provide details _____

Have you ever received Pneumovax (vaccine to prevent pneumonia)? ☐ No ☐ Yes, if yes, Date _____

Have you ever received a shingles vaccine? ☐ No ☐ Yes, if yes, Date of last _____

Have you ever received an influenza vaccine? ☐ No ☐ Yes, if yes, Date of last _____

SURGERIES

Have you ever had surgery? ☐ No ☐ Yes

If yes, please indicate type of operation *Date*

_____ _____

_____ _____

_____ _____

SCREENING TESTS

Please tell us when you last had a:

1) Stool test for blood: Date: _____
2) Sigmoidoscopy or colonoscopy: (circle which) Date: _____

Women:

3) Pap Smear: Date: _____
4) Mammogram: Date: _____

Men:

5) Prostatic Specific Antigen: Date: _____

HABITS

Do you drink alcoholic beverages? _____ What? _____

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? _____

How many cups of coffee or tea do you drink daily? _____

Have you ever chewed tobacco? ☐ No ☐ Yes

Have you ever smoked marijuana? ☐ No ☐ Yes

Are you on a special diet? ☐ No ☐ Yes _____

Do you take vitamins? ☐ No ☐ Yes _____

Have you traveled outside of the U.S.A. in the past year? ☐ No ☐ Yes

Do you exercise? ☐ No ☐ Yes

If yes, what type and how often? _____

What do you enjoy doing? _____

To what do you attribute your present state of health? _____

FAMILY HISTORY

		IF LIVING			IF DECEASED	
	Name	Age	Health		Age	Cause
Mother						
Father						
☐Sister ☐Brother						
☐Sister ☐Brother						
☐Sister ☐Brother						
☐Sister ☐Brother						
Spouse/Companion						
☐Son ☐Daughter						
☐Son ☐Daughter						
☐Son ☐Daughter						
☐Son ☐Daughter						
☐Son ☐Daughter						

Please list all relatives with a history of cancer

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

HEMATOLOGY HISTORY

Have you been told you have a blood disorder? If so, describe when _____

Do you have any of the following?

1. Bleeding gums? ☐ No ☐ Yes
2. Easy bruising? ☐ No ☐ Yes

3. Frequent nose bleeds? ☐ No ☐ Yes

4. Frequent infections? ☐ No ☐ Yes

5. Bleeding complications from surgery? ☐ No ☐ Yes

6. Swollen lymph glands? ☐ No ☐ Yes

7. History of blood clots? ☐ No ☐ Yes

8. Family history of blood disorder? ☐ No ☐ Yes if so, specify _____

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* _____

SOCIAL HISTORY

Where were you born ? _____

How many people live in your home now? _____

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. Circle the number which best describes your symptoms. The nurse or doctor will discuss these with you during your visit.

EMOTIONAL 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: _____

PAIN (please circle one)

a. The **average** amount of pain I have had in the **last week**:

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

b. The **most** 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 **last week:**

a. My fatigue level has been:

0	1	2	3	4	5	6	7	8	9	10
None										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 activities; 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 activities or do active work.
☐ I require occasional assistance but am able to care for most of my own needs.

REVIEW OF SYSTEMS

Please check any of the following you have or have had problems with:

HEAD None ☐

☐ Trauma ☐ Headache

EYES None ☐

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

EARS None ☐

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

MOUTH None ☐

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

NOSE & THROAT None ☐

- ☐ Hoarseness
- ☐ Nose Bleeds
- ☐ Sinus Problems
- ☐ Change in Smell
- ☐ Change in Voice
- ☐ Nasal Obstruction
- ☐ Head Colds
- ☐ Runny Nose

RESPIRATORY None ☐

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

CARDIOVASCULAR None ☐

- ☐ Angina
- ☐ Abnormal Cardiogram (EKG)
- ☐ Shortness of Breath at Rest
- ☐ Shortness of Breath with Exertion
- ☐ Shortness of Breath at Night
- ☐ Shortness of Breath when Lying Flat
- ☐ Rapid Heart Beat
- ☐ Irregular Heart Beat (Palpitations)
- ☐ Pain: Jaw, Neck, Chest, Mid-Back
- ☐ Leg Cramps
- ☐ Varicose Veins or Phlebitis
- ☐ Swollen Feet or Ankles

GASTROINTESTINAL None ☐

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

MUSCULOSKELETAL None ☐

- ☐ Bone Pain
- ☐ Dislocations
- ☐ Joint: Stiffness, Swelling, Pain or Redness; which one(s): _____
- ☐ Muscle Pain
- ☐ Handicap
- ☐ Back Pain
- ☐ Sprains

SKIN None ☐

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

HEMATOLOGICAL None ☐

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

NEUROLOGICAL & PSYCHOLOGICAL None ☐

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

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

PAIN

Are you experiencing any pain? ☐ No ☐ Yes

*If yes, where is it located?*_____

*what is it from?*_____

*how intense is it?*_____

*what relieves or reduces it?*_____

GENITOURINARY None ☐

☐ Pain with Urination or Intercourse ☐ Dark or Red Urine

☐ Urinate Frequently During the Day: _____times

☐ Urinate Frequently During the Night: _____times

☐ Urine Stream: Weaker, Smaller, Dribbling, Difficulty Starting or Stopping

☐ Incontinence

SEXUALITY

Are you sexually active? ☐ No ☐ Yes

Are you having any problems with sexuality as a result of your condition?

_____

MEN

☐ Penis: Soreness, Discharge, Burning, Pain ☐ Testicle: Pain, Swelling, Lump

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 pregnancy? _____ Did you breast feed? _____

Birth Control Pills? ☐ No ☐ Yes

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

Breast: ☐ Lump ☐ Discharge ☐ Pain ☐ Swelling

Did you ever take Diethylstilbestrol (DES)? ☐ No ☐ Yes

Did your mother take Diethylstilbestrol (DES)? ☐ No ☐ Yes

Other Hormones (such as Estrogen, etc.)? ☐ No ☐ Yes

If yes, what? _____ *when?* _____

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? ☐ 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 you have, please provide us with a copy for your records.

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

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, i.e., how to find help at home (housekeeping, meal preparation, etc.),
☐ Transportation, attendant/nursing care, etc.
☐ Financial resources, programs, etc.

How can we help you? _____
_____

Patient Health History dictated by: _____ Date: _____