NORTON CANCER INSTITUTE

Orthopedic Oncology

New patient information form

Instructions:

Please answer the following questions. Your answers will help the staff plan and provide your care, as well as help us with our research to better understand the risk factors for cancer. Leave any part blank if you are unsure or if you do not wish to answer. We will review this form with you after you have completed it. Any information we gather will be kept confidential. Please use ink and print your answers. *Thank you*.

By what name do you prefer to be called: _____
Name of your spouse or primary care Giver: _____

Section 1: HEALTH HISTORY

1. Have you had any of the following illnesses? Please check **all** that apply.

☐ Arthritis	☐ Asthma	☐ Chickenpox
☐ Thyroid problems	☐ Lung Problems	☐ Migraines
☐ Goiter	☐ Emphysema	☐ Mumps
☐ Diabetes	☐ Seizures	☐ Psychiatric problems
☐ Cancer	☐ Colitis	☐ Rheumatic fever
☐ Anemia	☐ Ulcers	☐ Tuberculosis
☐ Bleeding Problems	☐ Liver problems	☐ Jaundice
☐ Circulation Problem	☐ Polio	☐ Hepatitis
☐ Heart attach	☐ Heart problems	☐ Kidney problems
☐ Measles	☐ High blood pressure	☐ Stroke
☐ HIV/AIDS Other:	☐ Other: _____	

2. Tell us about the surgeries you have had in the past. Please *include* eye and orthopedic surgeries.

Approximate Date	Type of surgery	Reason for surgery?

3. Other than hospitalizations for surgery, what *other* hospitalizations have you had in the past?

Approximate Date	Reasons for Hospitalization

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Section 2: MEDICATION HISTORY & ALLERGIES

List all the medications that you take. (include prescriptions, over-the-counter, vitamins and herbal products)			Do you have *medication* Allergies? ☐ No ☐ Yes	
Name of Medicine	How much do you take (dose)?	Why do you take it?	List your allergies and the reactions below:	
			Drug Allergies	Description of reaction
			Do you have *other types* of allergies: ☐ No ☐ Yes	
			List your allergies and reaction below:	
			Allergies	Description of reaction

Section 3: FAMILY HISTORY

			If Living		**If Deceased**	
			Age	Health Problems	Age	Cause of Death
Father						
Mother						
Brothers or Sisters & Children						
	M	F				
	M	F				
	M	F				
	M	F				

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	M	F				
	M	F				

Other than you mother, father, sisters or brothers, do you have any blood relative that has or has had any of the medial problems listed below? Describe their relationship to you.

Medical Problem	Relationship to you	Medical Problem	Relationship to you
Stroke		Kidney Disease	
Cancer		Nervous Breakdown	
High Blood Pressure		Asthma	
Tuberculosis		Bleeding Tendency	
Epilepsy		Blood Disorders	

Section 4: SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Widow

Where you were born? _____ _____
City State Country

In what City, State and Country have you lived the longest? _____

Heath Practices

When were you last immunized for:		When you were last tested for TB?	☐ Never	
Influenza "Flu Shot"	Date:		Date:	
Pneumovax	Date:		Results:	
Tetanus	Date:	Do you wear seatbelts?	☐ No	☐ Yes
Chickenpox	Date:	Do you exercise regularly?	☐ No	☐ Yes
MMR	Date:			

Tobacco Use:

☐ I have never smoked	☐ I have smoked at least 100 cigarettes (5 packs) during my lifetime	☐ I have quit smoking
	How many years have you smoked? ___	How long ago did you quit? ____
	Number of cigarettes smoked/day:____	Number of cigarettes smoked/day:_____

Other Tobacco Products: Do you use any of the tobacco products listed below? ___No ___Yes
if yes please complete the section below.

Chewing Tobacco	Snuff	Pipes	Cigars
☐ Yes Amount/Day_____	☐ Yes Amount/Day_____	☐ Yes How many years:_____	☐ Yes

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How many years:_____	How many years:_____	Amount/Day_____	How many years:_____ Amount/Day_____
☐ I Quit Years quit:_____	☐ I Quit Years quit:_____ __	☐ I Quit Years quit:_____	☐ I Quit Years quit:_____

Alcohol Use:

Drink alcoholic beverage regularly (at least 1 drink/Month)?	☐ Never	☐ Yes, (if yes, complete the section below)	☐ Yes, but I quit. Years since last drink___
		Average number of drinks a week: 12 oz. beer or wine coolers_____ 4-6 oz. glasses of wine: _____ 1 shot or jigger or liquor:_____	

Recreational Drugs

Have you ever used recreational drugs	☐ Never	☐ Yes, currently	☐ Yes, in the past drugs

Work History:

Are you currently able to work	☐ No	☐ Yes	☐ Yes, Part-time	☐ Retired	☐ Not Applicable

What is your current job? _____
If you are unable to work, when were you last able to work? _____
Have you applied for disability? ☐ No ☐ Yes effective date: _____
List any hazardous substance you may have been exposed to as a result of your current or past Job(s):_____
_____

Section 5: REVIEW OF SYSTEMS AND SYMPTOMS

In general, would you say your health is?

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

Fatigue

In the last week, have you been experiencing Fatigue?	☐ No, *If no proceed to the next section*			☐ Yes
During the last week, how often did you experience Fatigue?	☐ Occasionally	☐ Half of the time	☐ Most of the time	☐ All the time

Pain

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In the last week, have you been experiencing Pain?	☐ No, *If no proceed to the next section*			☐ Yes
During the last week, how often did you experience Pain?	☐ Occasionally	☐ Half of the time	☐ Most of the time	☐ All the time

To what extent has pain affected:

Moderate activities, moving a table, pushing a vacuum cleaner, bowling or playing golf	☐ Limited a little	☐ Limited a lot	☐ Not limited
Climbing a flight of stairs	☐ Limited a little	☐ Limited a lot	☐ Not limited

Nutrition

1. Have you unintentionally lost weight in the last month? ☐ No ☐ Yes How much? _____
2. Have you unintentionally gained weight in the last month? ☐ No ☐ Yes How much? _____

Fever

1. In the last week, have you:
   - ☐ Had a temperature greater than 100 degrees? ☐ No ☐ Yes
   - ☐ Had chills? ☐ No ☐ Yes

Please check all the following problems you currently have and/or have had in the past:

Skin

- ☐ ***No problems***
- ☐ Abnormal growths
- ☐ Changes in hair and nails
- ☐ Changes in skin color
- ☐ Itching
- ☐ Lumps
- ☐ Rashes
- ☐ Sores or wounds
- ☐ Unusual dryness

EYES, EARS, NOSE AND THROAT

- ☐ ***No problems***
- ☐ Bleeding gums
- ☐ Changes in taste
- ☐ Dental problems
- ☐ Difficulty chewing
- ☐ Dry mouth
- ☐ Earache
- ☐ Hearing changes
- ☐ Hoarseness
- ☐ Lumps in the neck
- ☐ Nosebleed
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Sores in mouth or throat
- ☐ Swollen neck glands
- ☐ Vision changes

Respiratory

- ☐ *No problems*
- ☐ Sputum or phlegm
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular

- ☐ *No problems*
- ☐ Chest pain
- ☐ Fast heart beat
- ☐ Irregular heart beat
- ☐ Leg pain
- ☐ Leg cramps when walking
- ☐ Swelling in feet or ankles
- ☐ Walking at night with shortness of breath

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Gastrointestinal

- ☐ *No problems*
- ☐ Black stools
- ☐ Blood in stool
- ☐ Changes in appetite
- ☐ Constipation
- ☐ Cramping
- ☐ Diarrhea
- ☐ Indigestion/heartburn
- ☐ Hemorrhoids
- ☐ Hiccups
- ☐ Nausea
- ☐ Problems swallowing
- ☐ Reflux
- ☐ Stomach pain
- ☐ Unable to control bowels
- ☐ Vomiting
- ☐ Yellow skin or eyes

Urinary

- ☐ *No problems*
- ☐ Bladder infections
- ☐ Blood in urine
- ☐ Burning with urination
- ☐ Dribbling
- ☐ Frequency
- ☐ Nocturia (frequent urination at night)
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Unable to control urine

Musculoskeletal

- ☐ *No problems*
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling

Neurological/Psychiatric

- ☐ *No problems*
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Unsteady walking
- ☐ Dizziness
- ☐ Tremor
- ☐ Lack of coordination
- ☐ Fainting
- ☐ Falls
- ☐ Headache
- ☐ Memory changes
- ☐ Numbness
- ☐ Restlessness
- ☐ Ringing in the ears
- ☐ Speech changes
- ☐ Stiffness
- ☐ Tension
- ☐ Trouble sleeping
- ☐ Weakness of arms or legs

FOR MEN ONLY

- ☐ Difficulty passing urine
- ☐ Enlarged prostate

FOR WOMEN ONLY

- ☐ Breast changes
- ☐ Breast lumps
- ☐ Nipple discharge
- ☐ Unusual vaginal bleeding
- ☐ Heavy menstrual bleeding

Age at first menstrual period:

__

Date of last menstrual period:

__

Number of **pregnancies**:

____

Number of **deliveries**: ____

Last **PAP** smear: _____

☐ Never had a **PAP** smear

Last mammogram: _____

☐ Never had a mammogram