

Please fill out the following health history. This information is kept confidential and will not be released except when you have authorized us to do so.

Name _____ Date of Birth _____ Age _____ Date _____
 Reason for Visit _____ Family or Referring Physician _____
 Social Security Number _____ Sex _____ Marital Status _____ Do you have an Advanced Directive _____
 Address _____ City/Zip _____ Phone _____
 Occupation/Place of Employment _____ Work Phone _____ May we contact you there _____
 Person to Notify _____ Relationship _____ Phone _____
 Alternative Person to Notify _____ Relationship _____ Phone _____
 1st Insurance Co. _____ Policy Holder's Name _____ Date of Birth _____
 Address _____ Sub # _____ Group # _____
 2nd Insurance Co. _____ Policy Holder's Name _____ Date of Birth _____
 Address _____ Sub # _____ Group # _____

Medicare Questions Only Date of Retirement _____ Veteran: Yes No Kidney Disease: Yes No
 Black Lung Program: Yes No Work Comp.: Yes No Disability: Yes No If yes, date of disability _____

SYMPTOMS

Check conditions you currently have or have had in the past

<p>GENERAL</p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats Comments: _____</p> <p>MUSCLE-SKELETAL</p> <p>Pain, weakness, numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders Comments: _____</p> <p>GENITO-URINARY</p> <p><input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Lack of Bladder Control <input type="checkbox"/> Painful Urinations Comments: _____</p>	<p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Poor Appetite <input type="checkbox"/> Bloating <input type="checkbox"/> Bowl Changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Vomiting Comments: _____</p> <p>CARDIOVASCULAR</p> <p><input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Swelling in Ankles <input type="checkbox"/> Blood Clots Comments: _____</p>	<p>HEAD & NECK</p> <p><input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Double Vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Sinus Problems Comments: _____</p> <p>SKIN</p> <p><input type="checkbox"/> Bruise Easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in Mole <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Non-Healing Sore Comments: _____</p>	<p>MEN ONLY</p> <p><input type="checkbox"/> Breast Lump <input type="checkbox"/> Erection Difficulties <input type="checkbox"/> Lump in Testicles <input type="checkbox"/> Penis Discharge <input type="checkbox"/> Sore Penis Comments: _____</p> <p>WOMEN ONLY</p> <p><input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Breast Lump <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Vaginal Discharge Date of last menstrual period _____ Date of last pap smear _____ Are you pregnant? _____ Have you had a mammogram? _____ If yes, when? _____ Number of pregnancies: _____ Number of children: _____ Comments: _____</p>
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MEDICATIONS

Please list the medicines you are currently taking

1. _____ Reason: _____ 2. _____ Reason: _____
 3. _____ Reason: _____ 4. _____ Reason: _____
 5. _____ Reason: _____ 6. _____ Reason: _____
 Pharmacy Name: _____ Phone: _____
 Medication/Food Allergies: _____



HISTORY AND HEALTH ASSESSMENT

PATIENT LABEL

CONDITIONS

Please check conditions you currently have or have had in the past year.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ADIS | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |

Comments: _____

HOSPITALIZATIONS / SURGERY

YEAR	NAME of HOSPITAL	REASON FOR HOSPITALIZATION & OUTCOME

FAMILY HISTORY

Please fill in health information about your family. Please indicate male or female.

Relationship	Age	Age at Death	Current State of Health	Cancer History	Cause of Death

Check if YOUR BLOOD relative has any of the following and their relationship to you

- | | | | |
|--------------------------|--------------------|---------------------------|--------------------|
| Arthritis _____ | Colitis _____ | High Blood Pressure _____ | Migraine _____ |
| Asthma _____ | Diabetes _____ | Kidney Disease _____ | Stroke _____ |
| Bleeding Disorders _____ | Epilepsy _____ | Leukemia _____ | Suicide _____ |
| Cancer _____ | Heart Attack _____ | Nervous Breakdown _____ | Tuberculosis _____ |

HEALTH HABITS

Please check which applies to you

Tobacco use, if so how much? _____ How long? _____ Alcohol use, if so how much? _____ How long? _____
 Date of last dental exam: _____ Date of last eye exam: _____
 What is your biggest fear? _____



**HISTORY AND HEALTH
ASSESSMENT**

PATIENT LABEL

PAIN ASSESSMENT

Are you currently experiencing pain related to your diagnosis of cancer? ___ No ___ Yes If yes please continue.
 What is the reason for your pain? _____ Where is your pain located? _____

What techniques / medications help to relieve your pain? _____

How much is relieved by medication? ___ All ___ Almost All ___ Very Little ___ None _____

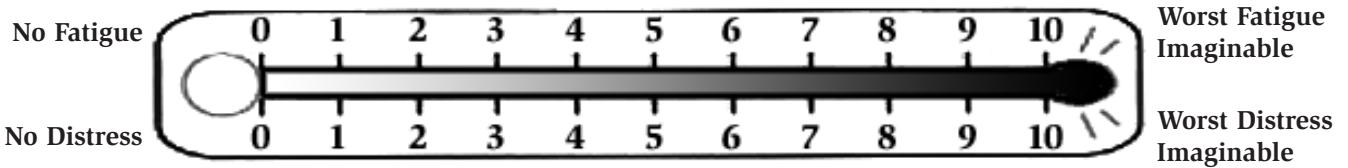
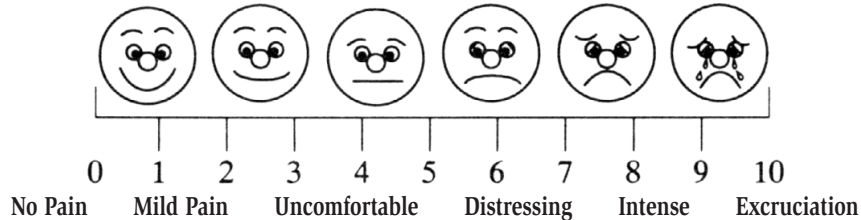
Are you having any constipation? ___ Yes ___ No If yes, what do you do for constipation? _____

Please circle the type/types of pain that you are having?

Ache Throb Burning Tingle Sharp Stabbing

Other: _____

Please mark the level of your pain, fatigue, and distress using the scales below.



Please notify your nurse or physician if you are having persistent pain/fatigue/distress.

THE REMAINDER OF THE FORM IS FOR STAFF USE ONLY. THANK YOU

Are the medications prescribed effective? Yes No If no, refer to the medical record for interventions

Is constipation an identified problem Yes No If yes, refer to the medical record for interventions

Does the patient need additional support for pain management? Circle identified factors.

 cultural spiritual ethical familial values

Referred to: _____ **Date:** _____

Barriers to Learning: emotional motivational financial physical cognitive language

Referred to: _____ **Date:** _____

Goals for Treatment of Pain: Eliminate Ease Other: _____

Document in the medical record pain assessment, intervention, plan of care, and evaluation of the patients pain, per department specific Pain Assessment and Management Policy.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Would you like a copy of your medical record sent to your physician(s)? Yes ___ No ___

Name of Physician: _____

Signature: _____ Date: _____

Reviewed By: _____ Date: _____



