Oncology Nevada Questionnaire Form

First Name: _____ Last Name: _____ DOB: _____

Preferred Laboratory: _____ Preferred Imaging Center: _____ Preferred Pharmacy: _____

Primary Care Physician: _____

History:

Medical Problems	Past Surgeries
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you had previous **Radiation Therapy**? ○NO ○YES, please explain: _____

Have you had previous **Chemotherapy**? ○NO ○YES, please explain: _____

Are you adopted? ○NO ○YES, **if so, please skip the following biological family questions below.**

What is your **father's** status?

○ Living and well ○ Deceased as a result of: _____ ○ Medical Problems: _____

History of cancer? _____

What is your **mother's** status?

○ Living and well ○ Deceased as a result of: _____ ○ Medical Problems: _____

History of Cancer? _____

Do you have any **siblings** with a history of cancer? If so, please explain: _____

_____

Do you have **children** with a history of cancer? If so, please explain: _____

_____

Smoking status: ○Never. **Please skip following questions.**

○ current everyday smoker ○ former smoker. I quit _____ years ago.

What kind of substance: ○ Cigarettes ○ Cigar ○ Dip/Chew ○ Pipe ○ Marijuana

What year did you start smoking? _____ How many packs per day? _____

Alcohol Consumption: ○Never. **Please skip following questions.**

○ every day drinker ○Ocassional drinker ○Former. I quit_____years ago.

How many drinks per day? _____

Have you been in contact with hazardous material? ○NO ○YES, please name:_____

Support System:

Marital Status: _____ With whom do you live with? _____

Do you live in a ○ Home ○ Nursing home ○ Assisted living ○ Other:_____

Do you require transportation? ○NO ○YES

Review of systems: In the past 3-6 months, have you experienced the symptoms below?

Loss of appetite	YES	NO	Neck pain	YES	NO
Fatigue	YES	NO	Motion range in neck decrease	YES	NO
Fever	YES	NO	Swelling in the neck	YES	NO
Lethargic	YES	NO	Blisters	YES	NO
Weakness/overall discomfort	YES	NO	Bruising	YES	NO
Night Sweats	YES	NO	Dry skin	Yes	NO
Chills	YES	NO	Facial burning	YES	NO
Weight Change	YES	NO	Change in nails	YES	NO
Hair loss	YES	NO	Itching of the skin	YES	NO
Blurred vision	YES	NO	Rash	YES	NO
Double Vision	YES	NO	Headaches	YES	NO
Overflow of tears	YES	NO	Hives	YES	NO
Night Blindness	YES	NO	Breast Mass	YES	NO
Visual Difficulties	YES	NO	Nipple discharge	YES	NO
Difficulty swallowing	YES	NO	Nipple inversion	YES	NO
Ear pain	YES	NO	Pain in the breasts	YES	NO
Bleeding from the nose	YES	NO	Irregular Heartbeat	YES	NO
Inflammation of esophagus	YES	NO	Chest pain	YES	NO
Difficulty hearing	YES	NO	Labored breathing	YES	NO
Mouth Dryness	YES	NO	Edema	YES	NO
Oral bleeding	YES	NO	Fast beating heart	YES	NO
Ear infection	YES	NO	Cough	YES	NO
Sinus infections	YES	NO	Coughing up blood	YES	NO
Inflammation of the stomach	YES	NO	Suffer from hiccups	YES	NO
Change in taste	YES	NO	Abdominal pain	YES	NO
Ringing in ears	YES	NO	Change in bowel habits	YES	NO
Neck mass	YES	NO	Constipation	YES	NO
Muscle weakness in neck	YES	NO	Diarrhea	YES	NO
Heartburn	YES	NO	Disorientation	YES	NO

Review of systems continue: In the past 3-6 months, have you experienced the symptoms below?

Blood in Stool	YES	NO	Dizziness	YES	NO
Chest pain	YES	NO	Walking abnormalities	YES	NO
Hemorrhoids	YES	NO	Headaches	YES	NO
GI bleeding	YES	NO	Insomnia	YES	NO
Nausea	YES	NO	Memory loss	YES	NO
Pain/cramping	YES	NO	Neuropathy	YES	NO
Vomiting	YES	NO	Paralysis	YES	NO
Painful urination	YES	NO	Seizure	YES	NO
Change in urination frequency	YES	NO	Sensory problems	YES	NO
Blood in Urine	YES	NO	Stroke	YES	NO
Incontinence	YES	NO	Delusions	YES	NO
Frequent urination at night	YES	NO	Hallucinations	YES	NO
Renal stone disease	YES	NO	Depression	YES	NO
Urgency to urinate	YES	NO	Mood swings	YES	NO
Change in urine color	YES	NO	Diabetes	TES	NO
Arthritis	YES	NO	Hot flashes	YES	NO
Bone pain	YES	NO	Thyroid disease	YES	NO
Joint pain	YES	NO			
Muscle weakness	YES	NO			
Decrease in range of motion	YES	NO			

Cardiac Device Questions

Do you have an implanted cardiac device? ○NO ○YES, please skip following questions.

Who is your cardiologist? _____

Do you have a defibrillator or pacemaker? (Please circle one)

If you have a pacemaker, are you "pacemaker dependent" (i.e.- your heart will not beat at all Without the pacemaker? ○NO ○YES

**** If have you a pacemaker or defibrillator, please give the ID card to the receptionist to make copy of card.**

Gynecology (FEMALE ONLY)

of pregnancies: _____
# of live births: _____
# of miscarriages: _____
# of abortions: _____
Age menstruation started: _____

How often do you menstruate? _____
Last menstrual period: _____
Menstrual cycle length: _____
Menopause completed? ○YES ○NO
Last pap smear? _____ Normal? ○NO ○YES

Are you on birth control pills ○YES ○NO
History of hormone/estrogen ○YES ○NO
Are you pregnant ○YES ○NO

History of breast surgery ○YES ○NO
Family history of breast cancer ○YES ○NO
Did you breastfeed your children ○YES ○NO
Do you have vaginal discharge ○YES ○NO
Excessive vaginal bleeding ○YES ○NO