Levine Cancer Institute Patient Questionnaire

Last Name _____ First Name _____
Date of Birth _____ Phone Number _____

Have you filled out this form for Levine Cancer Institute in the last 14 days? □ Yes □ No
If yes, you only need to fill out pages 2 & 3

Primary Care Provider_____
Referred By _____
Reason for Visit _____

Health Problems: Have you ever been told you have any of the following?
If Yes, please give details below

Anemia	□	Yes	□ No	High Cholesterol or Lipids	□	Yes	□ No
Arthritis	□	Yes	□ No	HIV	□	Yes	□ No
Asthma	□	Yes	□ No	Kidney Disease	□	Yes	□ No
Blood Clots/DVT/PE	□	Yes	□ No	Liver Disease	□	Yes	□ No
Cancer	□	Yes	□ No	Lung Disease	□	Yes	□ No
(Write the type of cancer in "Other" below)				Migraine Headaches	□	Yes	□ No
Diabetes	□	Yes	□ No	Mental Illness/Phobias	□	Yes	□ No
Heart Disease	□	Yes	□ No	Stroke	□	Yes	□ No
High Blood Pressure	□	Yes	□ No	Thyroid Disease	□	Yes	□ No

Other: _____

Surgery History: Have you ever had any of these?
If Yes, please give details below

				Year
Appendectomy (appendix taken out)	□	Yes	□ No	_____
CABG (Coronary Artery Bypass Grafting)	□	Yes	□ No	_____
Cardiac (heart) stent	□	Yes	□ No	_____
C-Section	□	Yes	□ No	_____
Gallbladder Removal (gallbladder taken out)	□	Yes	□ No	_____
Hysterectomy (uterus taken out)	□	Yes	□ No	_____
Breast Surgery	□	Yes	□ No	_____

Other: _____

Family History:

Mother	□ Cancer (Type:_____) □ Blood Disorders □ Heart Disease □ Diabetes □ Stroke □ Other _____
Father	□ Cancer (Type:_____) □ Blood Disorders □ Heart Disease □ Diabetes □ Stroke □ Other _____
Spouse	□ Cancer (Type:_____) □ Blood Disorders □ Heart Disease □ Diabetes □ Stroke □ Other _____
Brother/Sister	□ Cancer (Type:_____) □ Blood Disorders □ Heart Disease □ Diabetes □ Stroke □ Other _____
Brother/Sister	□ Cancer (Type:_____) □ Blood Disorders □ Heart Disease □ Diabetes □ Stroke □ Other _____
Son/Daughter	□ Cancer (Type:_____) □ Blood Disorders □ Heart Disease □ Diabetes □ Stroke □ Other _____
Son/Daughter	□ Cancer (Type:_____) □ Blood Disorders □ Heart Disease □ Diabetes □ Stroke □ Other _____

Social History:

Ethnicity □ Asian □ African-American □ Hispanic □ Native American □ White □ Other _____

Job : _____

Who lives with you? _____

Do you drink alcohol? □ Yes □ No How Much? _____ Quit ? □ Yes □ No When? _____

Do you smoke? □ Yes □ No How Much? _____ Quit ? □ Yes □ No When? _____

Do you use chewing tobacco? □ Yes □ No How Much? _____ Quit ? □ Yes □ No When? _____

Are you often around people who are smoking? □ Yes □ No

Do you use IV drugs or have you in the past? □ Yes □ No

Do you have any of these signs?

Overall Body

Fever □ Yes □ No
Sweats □ Yes □ No
Feel very tired (fatigue) □ Yes □ No
Weight loss □ Yes □ No

Eye

Sight or vision problems □ Yes □ No
Blurred vision □ Yes □ No
Double vision □ Yes □ No

Ears, Nose, Mouth, & Throat

Hearing loss □ Yes □ No
Stuffy nose □ Yes □ No
Sore throat □ Yes □ No

Respiratory (lungs)

Hard time breathing □ Yes □ No
Cough □ Yes □ No
Coughing up phlegm or mucus □ Yes □ No
Wheezing □ Yes □ No

Cardiovascular (heart)

Chest pain □ Yes □ No
Heart races or skips a beat □ Yes □ No

Gastrointestinal (stomach and bowels)

Nausea (upset stomach) □ Yes □ No
Vomiting (Throwing up) □ Yes □ No
Diarrhea (loose bowel movements) □ Yes □ No
Constipation (hard to have a bowel movement) □ Yes □ No
Bloody stools □ Yes □ No

Genitourinary (sex organs and bladder)

Blood in urine (pee) □ Yes □ No
Change in urine stream □ Yes □ No
Other fluids come out when I pee □ Yes □ No
Problems when having sex □ Yes □ No

Blood/Lymph

Bruise easily □ Yes □ No
Bleed easily □ Yes □ No
Swollen lymph nodes □ Yes □ No

Endocrine (glands and hormones)

Feel very thirsty □ Yes □ No
I often feel cold □ Yes □ No
I often feel hot □ Yes □ No

Immune System

Fevers happen often □ Yes □ No
Infections happen often □ Yes □ No

Bones and Muscles

Back pain □ Yes □ No
Joint pain □ Yes □ No
Muscle pain □ Yes □ No

Skin

Rash □ Yes □ No
Itching □ Yes □ No

Neurologic (nerves)

Feel numb □ Yes □ No
Tingles □ Yes □ No
Headache □ Yes □ No

Psychiatric (mental health)

Often worried or nervous □ Yes □ No
Often feel very sad or low □ Yes □ No
Thinking of harming yourself □ Yes □ No
Thought's of killing yourself □ Yes □ No

Gynecologic (for women)

Could you be pregnant? □ Yes □ No
Period is not normal □ Yes □ No
Has your Ovary(s) been removed? □ Yes □ No
Abnormal Pap Smear □ Yes □ No

Last Name _____ First Name _____
Date of Birth _____ Phone Number _____

What medicines do you take? Write down all prescription and over the counter medicines you take. Include vitamins, herbs, aspirin, antacids, medicine given in a shot, hormones, and birth control.
Please bring all your medicines or a printed list with you

Medicine	Dose (how much you take)	How often do you take it?

Are you allergic to any medicines? □ Yes (Please list below) □ No

_____

_____

Are you allergic to latex? □ Yes □ No

Are you against using blood products? □ Yes (Please list below) □ No

_____

_____

Patient Signature_____ Date:_____ Time:_____

Atrium Health

Place Patient Label Here