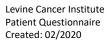
Last Name Date of Birth					First Name Phone Number							
	out this form for Levine C need to fill out pages 2 &		Institu	ıte ir	າ the last	14 days?		Yes		No		
Primary Care Pro Referred By Reason for Visit	ovider											
Health Problems If Yes, please giv	s: Have you ever been to e details below	old you	ı have	any	of the fo	llowing?						
Anemia Arthritis Asthma Blood Clots/DVT Cancer (Write the type of can Diabetes Heart Disease High Blood Press	cer in "Other" below)		Yes Yes Yes Yes Yes Yes		No No No No No No	High Cholesterd HIV Kidney Disease Liver Disease Lung Disease Migraine Heada Mental Illness/F Stroke Thyroid Disease	iches Phobia			Yes Yes Yes Yes Yes Yes Yes Yes		No No No No No No No
Other:												
If Yes, please giv Appendectomy (CABG (Coronary Cardiac (heart) s C-Section Gallbladder Rem Hysterectomy (u Breast Surgery Other:	appendix taken out) Artery Bypass Grafting) tent oval (gallbladder taken o		se?					Yes Yes Yes Yes Yes Yes		No No No No No No		Year
Family History:	□ Cancer (Type:) ⊔ 6		Disorders	□ Heart Disease	□ Dia	hetes	□ Stroi	 ke ⊓	Other	
Mother Father	Cancer (Type:											
Spouse	□ Cancer (Type:) _□ B	lood	Disorders	□ Heart Disease	□ Dia	abetes	□ Strok	.е п	Other	
Brother/Sister	□ Cancer (Type:		 _) 🗆 B	lood	Disorders	□ Heart Disease	□ Dia	abetes	□ Strok	.e п	Other	
Brother/Sister	□ Cancer (Type:) 🗆 B	lood	Disorders	□ Heart Disease	□ Dia	abetes	□ Strok	.e п	Other	
Son/Daughter	□ Cancer (Type:) _□ B	lood	Disorders	□ Heart Disease	□ Dia	abetes	□ Strok	.e п	Other	
Son/Daughter	□ Cancer (Type:		_) 🗆 B	lood	Disorders	□ Heart Disease	□ Dia	abetes	□ Strok	.е п	Other	



Levine Cancer Institute Patient Questionnaire Created: 02/2020



Social History:					
Ethnicity 🗆 Asian 🗆 African-American 🗆 Hispa	nic		nerican 🗆 White 🗆 Other		
Job:					
Who lives with you?					
Do you drink alcohol?		No How	Much? Quit? — Yes —	No	When?
Do you smoke?			Much? Quit? \(\text{Yes} \)	No	When?
Do you use chewing tobacco?			Much? Quit? \(\text{Yes} \)	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			Blood/Lymph		
Fever		Yes □ No	Bruise easily		Yes □ No
Sweats		Yes □ No	Bleed easily		Yes □ No
Feel very tired (fatigue)		Yes □ No	Swollen lymph nodes		Yes □ No
Weight loss		Yes □ No	<i>,</i> .		
-			Endocrine (glands and hormones)		
Eye			Feel very thirsty		Yes □ No
Sight or vision problems		Yes □ No	I often feel cold		Yes □ No
Blurred vision		Yes □ No	I often feel hot		Yes □ No
Double vision		Yes □ No			
			Immune System		
Ears, Nose, Mouth, & Throat			Fevers happen often		Yes □ No
Hearing loss		Yes □ No	Infections happen often		Yes □ No
Stuffy nose		Yes □ No	• •		
Sore throat		Yes □ No	Bones and Muscles		
			Back pain		Yes □ No
Respiratory (lungs)			Joint pain		Yes □ No
Hard time breathing		Yes □ No	Muscle pain		Yes □ No
Cough		Yes □ No	massic pain		
Coughing up phlegm or mucus		Yes □ No	Skin		
Wheezing		Yes □ No	Rash		Yes □ No
vviiceziiig			Itching		Yes 🗆 No
Cardiovascular (heart)			recining		103 🗆 110
Chest pain		Yes □ No	Neurologic (nerves)		
Heart races or skips a beat		Yes □ No	Feel numb		Yes □ No
riealt races of skips a beat	_		Tingles		Yes 🗆 No
Gastrointestinal (stomach and bowels)			Headache		Yes 🗆 No
Nausea (upset stomach)		Yes □ No	rieadactie	Ш	res 🗆 NO
			Davehiatria (mantal haalth)		
Vomiting (Throwing up)		Yes □ No	Psychiatric (mental health)		Vos 🗆 No
Diarrhea (loose bowel movements)		Yes □ No	Often worried or nervous		Yes □ No
Constipation (hard to have a bowel movement)		Yes □ No	Often feel very sad or low		Yes □ No
Bloody stools		Yes □ No	Thinking of harming yourself		Yes □ No
			Thought's of killing yourself		Yes □ No
Genitourinary (sex organs and bladder)			Gynecologic (for women)		
Blood in urine (pee)		Yes □ No	Could you be pregnant?		Yes 🗆 No
Change in urine stream		Yes □ No	Period is not normal		Yes □ No
Other fluids come out when I pee		Yes □ No	Has your Ovary(s) been removed?		Yes 🗆 No
Problems when having sex		Yes □ No	Abnormal Pap Smear		Yes □ No





Last Name Date of Birth	First Name 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?	lease list below)	□ No						
Are you allergic to latex?	□ No							
Are you against using blood products?	e list below) 🗆 No							



Patient Signature______ Date:_____ Time:_____