



Hope Cancer Care Center  
AT LONGMONT UNITED HOSPITAL

## Hope Cancer Care Health History Form – Important Information

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date: \_\_\_\_\_

Name Preferred \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Is it ok to leave you a voice mail message? Yes No On which phone(s)? \_\_\_\_\_

If you are employed, may we call you at work? Yes No

Primary Care Doctor: \_\_\_\_\_ Oncologist: \_\_\_\_\_

Surgeon: \_\_\_\_\_ Other Providers involved in your cancer care: \_\_\_\_\_

### **PAST MEDICAL HISTORY - Circle all that apply**

**Cancer:** Prior to your current diagnosis, have you had cancer? Yes No If so, what type? \_\_\_\_\_

**Cardiovascular:** Atrial Fibrillation Angina Chest Pain High Cholesterol Heart Attack

Congestive Heart Failure High Blood Pressure Irregular Heart Beat Murmur

**Pulmonary:** Asthma COPD Emphysema

**Gastrointestinal:** Crohns Disease Diverticulitis Ulcer Hepatitis Inflammatory Bowel Disease Reflux  
Ulcerative Colitis Hemorrhoids

**Genitourinary:** Kidney Stones Enlarged Prostate Renal Disease/Failure TURP

**ENT/Eye:** Chronic Sinus Infections Hearing Loss Cataract Retinal Disease Serious Eye Injury Glaucoma

**Hematology:** Anemia Blood Clots **Endocrine:** Thyroid disease Diabetes

**Immunological:** Sjogren's Syndrome Lupus Rheumatoid Arthritis Connective Tissue Disorder

**Infectious Disease:** Hepatitis Shingles Tuberculosis AIDS HIV

**Muscular skeletal:** Ankylosing Spondylitis Fibromyalgia Multiple Sclerosis Osteoarthritis

**Neuropsychiatric:** Alzheimer's/Dementia Bi-polar Disease Depression Migraines Claustrophobic

Parkinson's Schizophrenia Seizure Disorder Stroke Transient Ischemic Attack (TIA)

**Gynecologic:** Premenopausal Postmenopausal Date of last period \_\_\_\_\_

**Any possibility you may be pregnant?** Yes No

**Have you fallen in the last 3 months?** Yes No

**Past Chemotherapy:** Yes No Medications and Dates \_\_\_\_\_

Are there plans to receive chemo? Yes No If so, when? Date scheduled \_\_\_\_\_

**Past Radiation:** Yes No To what body part/dates/facility? \_\_\_\_\_

**PAST SURGICAL HISTORY:** List all prior surgeries with dates and any other health problems not listed above

**LIST MEDICATIONS YOU ARE CURRENTLY TAKING.** Also include herbal supplements, vitamins, nutritional supplements (i.e. Ensure, Boost)

**YOUR PHARMACY**

Name \_\_\_\_\_ Telephone # \_\_\_\_\_

**ARE YOU ALLERGIC TO ANY MEDICINES?** Yes No If so, please list: \_\_\_\_\_

**DO YOU HAVE OTHER ALLERGIES?** (I.e. tape, latex, food) If so, please list: \_\_\_\_\_

**FAMILY HISTORY:** Has anyone in your family had cancer? Yes No  
Which family member(s)? What age were they diagnosed with cancer? What type of cancer was it? What type of treatment did they have? What was the outcome?

Relationship to patient: F=Father, M=Mother, S=Sister, B=Brother, GM=Grandmother, GF=Grandfather,  
P=Paternal, M=Maternal

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**SOCIAL HISTORY:** Marital Status: S M W D Who do you live with? \_\_\_\_\_

In the event we cannot reach you, who can we speak to regarding your care? \_\_\_\_\_

Do you have any children and what ages are they? \_\_\_\_\_

Occupation: \_\_\_\_\_ Retired: Yes No

**Alcohol use?** Y/N **Circle all that apply:** Beer Wine Hard Liquor **Drinks per week**\_\_\_\_ **Drug use** Y/N

**Have you ever used tobacco products?** Y/N **What type:** \_\_\_\_\_ **How much?** \_\_\_\_\_

**For how many years?** \_\_\_\_\_ **Have you quit?** Y/N **When** \_\_\_\_\_

**Are you interested in smoking cessation?** Yes No

**Do you feel safe at home?** Yes No **What is your highest level of education?** \_\_\_\_\_

**What is your primary language?** \_\_\_\_\_

**Do you have any special needs such as hearing, vision or reading difficulties?** Yes No

**How do learn best?** Discussion Reading Video Hands-on

**NUTRITIONAL HISTORY:** How is your appetite? Good Fair Poor

Weight loss? No Yes, how many pounds? \_\_\_\_\_

Weight gain? No Yes, how many pounds? \_\_\_\_\_

Do you have any problems eating? No Yes, please explain \_\_\_\_\_

Are you following any special diets? (I.e. low salt, low fat, other) No Yes, please explain \_\_\_\_\_

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Would you like to see a dietitian? Yes No

**REVIEW OF SYSTEMS:** - Circle only if you have had these symptoms currently

**Constitutional:** Fatigue Fever Headache Trouble sleeping

**Ear/Nose/Throat:** Hearing loss Hoarseness Nasal congestion Ear or eye pain Ringing ears

Vision changes

**Respiratory:** Coughing blood Chronic cough Shortness of breath Chest pain Wheezing

**Cardiovascular:** Ankle swelling Awaken at night with shortness of breath

Inability to lay/sleep on back Chest pain Irregular heart beat Palpitations

**Vascular:** Leg ulcers Pain in legs

**Hematology:** Bleeding gums Bruise easily Blood clots

**Gastrointestinal:** Rectal bleeding Abdominal pain Constipation Diarrhea Heartburn Nausea Reflux

**Genitourinary:** Blood in urine Incontinence Painful urination Frequent urination

**Reproductive:** Abnormal vaginal bleeding Irregular menstrual cycles Pregnant

Trouble achieving/maintaining erection for sexual functioning

**Endocrine:** Elevated blood sugars Chronic fatigue Cold or heat intolerant Hair loss Swollen glands Hot Flashes

**Neurological:** Memory problems Numbness/tingling Seizures Confusion Headaches Dizziness

Trouble speaking or swallowing Poor balance Weakness in one area of the body more than others

**Psychiatric:** Frequent crying Suicide thoughts Depression Anxiety Excessive worry

**ADVANCE DIRECTIVES:**

**Do you have:** Living will    CPR Directive    Durable Medical Power of Attorney

**Name of Durable Medical Power of Attorney** \_\_\_\_\_

**Would you like more information about these topics?** Yes    No

**Would you like information about financial assistance?** Yes    No

**Information given by** \_\_\_\_\_ **Date** \_\_\_\_\_

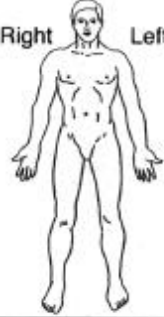
**PAIN ASSESSMENT**

1. If you are currently experiencing pain, please mark on the picture where you have pain.
2. Please rate your current pain level using the scale with the faces.

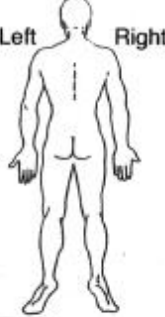
**Pain Information:**


Please mark on the picture where you have pain.

Right    Left



Left    Right





0-1    2-3    4-5    6-7    8-9    10

0    2    4    6    8    10

No pain    Mild pain    Moderate pain    Severe pain    Very severe    Worst possible

Please rate your current pain level using the scale above \_\_\_\_\_

**In the last year, have there been any major events in your life besides your current illness?**

Thank you for completing this history form. The information will be reviewed with you by a member of the staff and/or physician. This history form is part of your medical record for this practice and is strictly confidential.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date Reviewed \_\_\_\_\_