University Hospitals
Seidman Cancer Center

NEW PATIENT HEALTH HISTORY FORM

Thank you for taking the time to complete the New Patient Health History Form. This form will become part of your medical record. Please fill in the circle next to your answer or clearly print your answer when asked. You may use a pen or pencil to complete this form.

Today's date: ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

Patient's Name: _____ (First) _____ (Last) **Date of birth:** ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

Person completing this form: O Patient
O Other: (indicate relationship to patient) _____

Why have you come to the hospital today?
O Initial Consultation
O Second Opinion
O Transferring Care
O Other:

What is your medical reason for coming to the hospital?

Who referred you here?

Who is your family doctor? Phone

List any other doctors that you see: Phone Phone

Personal History

Please fill in the circle for all **previous** illnesses or conditions below:

O Anxiety/Depression
O Arthritis
O Bleeding Disorder
O Bowel/Intestinal Problems
O Diabetes (high blood sugar)
O Glaucoma/Eye Problems
O Hearing Problems
O Heart Attack/Disease
O High Blood Pressure
O History of Blood Clots
O HIV/AIDS
O Kidney Problems
O Liver Disease
O Lung Problems
O Mental Health Problems
O Seizures
O Skin Problems
O Stomach Problems
O Stroke
O Thyroid Disease

Other Health Problems:

Do you have a pacemaker or internal defibrillator? O Yes O No

Patient, please do not write in this space. (For Clinical Team Notes)

Have you had any past surgeries? ○ Yes ○ No

If **YES**, please list the surgery you had and the date:

	Month	Day	Year
_____	/	/	
_____	/	/	
_____	/	/	

Have you ever had any prior cancers (before your current illness of cancer)? ○ Yes ○ No

If **YES**, please list prior cancer, the date you were diagnosed, and the date of treatment completion:

Type of Cancer	Date of Diagnosis: Month / Day / Year	Date of Treatment Completion: Month / Day / Year
_____	/ /	/ /
_____	/ /	/ /

Have you had prior chemotherapy? ○ Yes ○ No

Have you had prior radiation treatment? ○ Yes ○ No

Medication

Please list any medications and supplements that you take on a daily or frequent basis. Include prescriptions and over-the-counter medications, vitamins, minerals, herbs, and any other supplements.

Medication	Dose	How often	Route (oral, topical, etc.)	What is it for?

Are you allergic to anything?

○ No ○ Yes, list all allergies and describe your reactions below:

Do you have any family history of chronic illnesses (for example, diabetes, heart disease or cancer)?

Family History

Please complete the family history form for yourself and "blood" relatives. Mark the second column for half siblings. Do not include any adopted children or stepbrothers/stepsisters. If you are adopted, and you do not know your natural parents, just complete information about your children. Use a "**?**" whenever you are not sure of an answer. If necessary, it is acceptable to estimate a date or an age.

Relationship:	Half-Sibling:	Initials:	Date of Birth:	Has this person ever had colonic polyps?			Has this person ever had cancer?			If Yes, please list type of cancer and age at diagnosis:		Is this person still living?		If not, please list cause of death and age at death:	
		First, Middle, Last	Month / Year	Yes	No	Don't Know	Yes	No	Don't Know	Type:	Age:	Yes	No	Cause:	Age:
You				○	○	○	○	○	○			●	○		
Mother				○	○	○	○	○	○			○	○		
Father				○	○	○	○	○	○			○	○		
Brother ○ Sister ○	○			○	○	○	○	○	○			○	○		
Brother ○ Sister ○	○			○	○	○	○	○	○			○	○		
Brother ○ Sister ○	○			○	○	○	○	○	○			○	○		
Brother ○ Sister ○	○			○	○	○	○	○	○			○	○		
Brother ○ Sister ○	○			○	○	○	○	○	○			○	○		
Brother ○ Sister ○	○			○	○	○	○	○	○			○	○		
Spouse/Parent of your children:				○	○	○	○	○	○			○	○		
Son ○ Daughter ○				○	○	○	○	○	○			○	○		
Son ○ Daughter ○				○	○	○	○	○	○			○	○		
Son ○ Daughter ○				○	○	○	○	○	○			○	○		
Son ○ Daughter ○				○	○	○	○	○	○			○	○		
Son ○ Daughter ○				○	○	○	○	○	○			○	○		
Son ○ Daughter ○				○	○	○	○	○	○			○	○		
Additional Spaces; please note relationships as needed:															
				○	○	○	○	○	○			○	○		
				○	○	○	○	○	○			○	○		
				○	○	○	○	○	○			○	○		
				○	○	○	○	○	○			○	○		
				○	○	○	○	○	○			○	○		
				○	○	○	○	○	○			○	○		
				○	○	○	○	○	○			○	○		
				○	○	○	○	○	○			○	○		

Would you like a referral to the Center for Human Genetics at University Hospitals Case Medical Center, which offers programs designed to help people with a family history of cancer? ○ Yes ○ No

Personal Information

Gender:
O Male
O Female

What is your race?
(Select all that apply)
O American Indian or Alaskan Native
O Asian
O Black or African American
O Native Hawaiian or Other Pacific Islander
O White

Are you Hispanic or Latino?
O Yes
O No

Relationship Status:
O Single O Divorced
O Married O Widowed
O Separated O Partnered

Spiritual practice/religious tradition:

Employment Status:
O Currently Working
O Retired
O On medical leave
O On disability
O Unemployed

Occupation (if applicable):

Did you serve in the military?
O Yes
O No

Who do you consider to be your family?

Who is your main support person?

What is their relationship to you?

What is their phone number?

Whom can we share information with?

Who takes care of you when you are ill?

Living Accommodations:
O House
O Apartment
O Extended Care Facility
O Other: _____

Living Arrangement:
O Alone
O With family/friends

How many children live in your household?

Are there times when you feel unsafe around people you know or live with?
O No O Yes

If you have children living in your household, what are their ages?

Highest level of education completed:
O Grade: _____
O High School
O 2 Year Degree
O 4 Year Degree
O Graduate Degree

How do you learn?
O Reading O Memorizing
O Listening O Demonstration
O Practicing O Other

Do you have problems with:
O Hearing O Speech O Sight

Do you need an interpreter?
O No O Yes

What is your primary language?

Current Health

Please fill in the circle of all of the following problems that you have had in the past 3 weeks.

General
- O None
- O Fever/Chills
- O Sweats
- O Change in sleep habits
- O Fatigue

Skin
- O None
- O Open sore
- O Change in moles
- O Abnormal color
- O Rashes

Urinary
- O None
- O Burning
- O Frequency
- O Dribbling
- O Unable to control bladder
- O Urgency

Lungs
- O None
- O Wheezing
- O Cough
- O Short of breath
- O Bloody phlegm/sputum

Hematology
- O None
- O Abnormal bleeding
- O Prior transfusion
- O Easy bruising
- O Swelling in groin/armpit/neck

Endocrine
- O None
- O Cold intolerance
- O Hot flashes

Musculoskeletal
- O None
- O Joint swelling
- O Joint/back pain
- O Stiffness
- O Trauma
- O Falls

Head & Neck
- O None
- O Nose bleeds
- O Hoarseness
- O Sores in mouth or throat
- O Sore throat

Last dentist visit:

☐☐ / ☐☐ / ☐☐☐☐

Heart
- O None
- O Leg pain/swelling
- O Chest pain
- O Fast heart beat

Gastrointestinal and Nutrition
- O None
- O Yellow skin or eyes
- O Cramping or stomach pain
- O Nausea/vomiting
- O Problems swallowing
- O Indigestion/heartburn
- O Reflux
- O Blood in stools
- O Black stools
- O Constipation
- O Diarrhea

Breast
- O None
- O Changes
- O Lumps
- O Nipple discharge

Date of last mammogram:

☐☐ / ☐☐ / ☐☐☐☐

Male Only
- O None
- O Problems passing urine
- O Enlarged prostate

Date of last prostate exam:

☐☐ / ☐☐ / ☐☐☐☐

Neurological
- O None
- O Memory changes
- O Numbness/tingling
- O Dizziness/fainting
- O Weakness
- O Blurred vision
- O Headache
- O Hearing difficulty
- O Ringing in ears
- O Seizures
- O Speech changes
- O Unbalanced walking

Female Only

- O Unusual bleeding/discharge

Date of last menstrual period

☐☐ / ☐☐ / ☐☐☐☐

Date of last pap smear

☐☐ / ☐☐ / ☐☐☐☐

Age at 1st menstrual period: ☐☐

Age at 1st pregnancy: ☐☐

Number of pregnancies: ☐☐

Number of live births: ☐☐

Have you ever taken birth control?

O Yes O No

If **YES**, how many years?

☐☐

Have you ever taken hormone replacement?

O Yes O No

If **YES**, how many years?

☐☐

Are you pregnant now? O Yes O No

Please list any other problems you are currently having:

Pain

Are you currently having pain?

O No
O Yes (If yes, where?)

Fill in the circle next to the number that best describes your pain.

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

No pain **Worst possible pain**

Activity

Over the past month, I would rate my activity as:

- O Normal, no limitations
- O Not my normal self, but able to be up doing fairly normal activities
- O Not feeling up to most things, in bed or chair less than half of the day
- O Able to do little activity, spend more than half the day in bed or a chair
- O Rarely out of bed or chair

How would you rate your fatigue on a sale of 0-10 over the past 7 days?

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

No Fatigue **Worst fatigue you could imagine**

Do you need help with:	Yes	No
O Bathing/dressing	O	O
O Walking	O	O
O Stairs	O	O
O Preparing Meals	O	O
O Other:	O	O

Home Health Care Used:

O None
O University Home Care
O VNA
O Other:

Community Agencies Used:

O None
O Support Group
O Meals on Wheels
O Other:

Coping

It is normal to feel some distress when you are ill. Please fill in the circle next to the number that best describes your level of distress on average, **over the past week:**

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

No Distress **Most severe distress**

Check the factors that you feel contribute to your distress:

Practical:	Physical:	Emotional:	Communication:	Spiritual/Religious: Concerns
O Housing	O Pain	O Worry	O Communication with partner	O Relating to God
O Insurance	O Nausea	O Sadness	O Communication with children	O Loss of faith
O Work/School	O Fatigue	O Depression	O Communication with doctor	
O Transportation	O Sleep problems	O Nervousness		
O Childcare	O Getting around	O Hopelessness		
O Financial Concerns				

Would you like more information about a support group? O Yes O No

Would you like more information about individual supportive counseling? O Yes O No

Diet

What is your current height and weight?

Feet Inches Pounds

What did you weigh 1 month ago, 6 months ago and 1 year ago?

1 month 6 months 1 year

How would you describe your diet?

O Regular O Low Cholesterol
O Diabetic O Vegetarian
O Low Salt O Other:
O Low Fat

Compared to normal, how would you rate your food intake during the past month?

O Unchanged
O More than usual
O Less than usual

What are you currently eating?

O Regular foods
O Soft foods
O Liquid supplements
O Only liquids

My appetite is:

O Very Poor O Poor O Average O Good O Very Good

Would you like to meet with our registered dietitian? O Yes O No

Lifestyle

Exercise

Moderate intensity exercise includes physical activities that get you breathing harder and your heart beating faster. Examples of exercise include setting aside time for things like: jogging, dancing, bike riding, aerobic classes, swimming, working out to an exercise video. Exercise does not include what you do at work. Use this definition to answer the questions below.

During the last 6 days, on how many days did you do moderate intensity exercise for at least 10 minutes at a time without stopping? ☐☐ **0-7 days / week**

On those days, how much time did you spend on average doing the activities? ☐☐☐ **minutes**

Walking fast (3-4 mph) is also exercise. During the last 7 days, on how many days did you walk fast for at least 10 minutes at a time without stopping? ☐☐ **0-7 days / week**

On those days, how much time did you spend on average walking fast? ☐☐☐ **minutes**

Compared to how physically active you have been over the last 3 months, how would you describe the last 7 days?

○ More active ○ About the same ○ Less Active

Have you ever used tobacco products? ○ Yes ○ No

If **YES**, what type/s?

○ Cigarettes	☐☐ # packs/day	☐☐ # of years
○ Cigars	☐☐ # per day	☐☐ # of years
○ Little Cigars	☐☐ # per day	☐☐ # of years
○ Chewing tobacco	☐☐ # per day	☐☐ # of years
○ Other tobacco (Snuff, Hookah, Bidis, Kretecks etc.)	What product: ☐	How often: ☐ ☐☐ # of years

If **YES**, have you quit? ○ Yes - when? ☐☐ / ☐☐ / ☐☐☐☐ ○ No

Do you drink alcohol? (include beer & wine) ○ Yes ○ No

If **YES**, how many **days** did you drink in the past week? ☐ # days/week

If **YES**, how many **drinks** did you have in the past week? ☐☐ # of drinks

Did you previously drink alcohol, but have since quit? ○ Yes ○ No

Do you use recreational drugs? ○ Yes ○ No

If **YES**, what drugs do you use and how often do you use them?

☐ # days/week

☐ # days/week

Did you previously use recreational drugs, but have since quit? ○ Yes ○ No

Health Care Documents

	Yes	No
Do you have an Advance Directive? (Durable Power of Attorney for Health Care)	○	○
Do you want help completing an Advance Directive?	○	○
Do you have a living will?	○	○
Do you want help completing a living will?	○	○
Do you have a legal guardian?	○	○

What is your main concern regarding your illness and treatment?

What else would you like us to know about you?

What questions may we answer for you?

Thank you for completing this form. Please bring it with you to your doctor's appointment.

Patient Signature

Healthcare Team Member Signature, Title

Date

Patient, please do not write in this space. (For Clinical Team Notes)