FIRST DAYTON CANCER CARE

Name _____ **R.T. No.** _____ **Date** _____

MEDICAL HISTORY (Check only those that apply)

TEETH
☐ Dentures ☐ up ☐ low
Last dental visit :
_____

HEARING
☐ Hearing Aid ☐ R ☐ L
☐ Deaf

VISION
☐ Glasses
☐ Contacts
☐ Artificial Eye
☐ Blind
☐ Cataracts

IMPLANTED DEVICES
☐ Pacemaker
☐ Venous access
☐ Cardioverter/ Defibrillator
☐ Other
_____

Have you ever had a problem with: (Check only those that apply)

☐ Bowel/Rectal bleeding
☐ Stomach/Hiatal hernia
☐ Kidney/Bladder/Prostate
☐ High Blood Pressure
☐ Diabetes
☐ Low Blood Sugar
☐ HIV/Venereal Disease
☐ Nerves
☐ Heart/Murmur
☐ Knees/Hips
☐ Seizures
☐ Thyroid
☐ Breathing
☐ Stroke
☐ Hepatitis/Liver
☐ Tuberculosis
☐ Back
☐ Pneumonia/Emphysema
☐ Neck/Jaws
☐ Walking
☐ Arthritis
☐ Gynocological Problem
☐ Depression
☐ Other

Comments: _____

PSYCHOSOCIAL

Are you troubled by: Worry about your family? ☐ Always ☐ Sometimes
Feeling sad? ☐ Always ☐ Sometimes

Have you discussed your sickness and treatments with your family or friends? ☐ Yes ☐ No
If yes, was it helpful? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Number of Pregnancies _____ Number of Children _____

Who lives at home with you? ☐ Spouse ☐ Children ☐ Parents ☐ Other ☐ Live alone
Who helps you at home? ☐ Spouse ☐ Children ☐ Parents ☐ Other ☐ Live alone

Does this person have health problems? ☐ Yes ☐ No

What helps you when you are upset (your coping mechanisim)? _____

_____

Do you need help with rides getting to and from the doctor and/or hospital? ☐ Yes ☐ No

Are you receiving agency support? ☐ None ☐ Visiting Nurse ☐ Meals on Wheels ☐ Physical Therapy
☐ Other _____

COMFORT LEVEL

Do you have pain? ☐ Yes ☐ No If yes, where? _____

How long does the pain last? _____

What gives you relief from the pain? _____

Does your pain prevent you from normal activities? ☐Yes ☐ No

If yes, please explain _____

PREVIOUS CHEMOTHERAPY ☐ Yes ☐ No

If yes, when & where? _____

PREVIOUS RADIATION ☐ Yes ☐ No

If yes, when & where? _____

OPERATIONS

Type	Date	Type	Date

Did you have any bleeding problems? ☐ Yes ☐ No

If yes, please explain _____

PREVIOUS PROBLEMS WITH ANESTHESIA ☐ Yes ☐ No

If yes, please explain _____

MEDICATIONS

Name	Dose	Times/Day

ALLERGIES to medications: ☐ Penicillin ☐ Sulfa ☐ Other _____

to food: _____

HABITS

Smoking ☐ Yes ☐ No (If checed No but smoked previously, please complete)

Amount _____ No. Years _____

Alcohol ☐ Yes ☐ No

Amount _____ No. Years _____

Exercise ☐ Yes ☐ No If yes, type of activity & amount

_____

FAMILY HISTORY

	Relationship	Type
Cancer		
Other Diseases/Illnesses		