Hunterdon Health
Hunterdon Regional Cancer Center
Hunterdon Medical Center
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HunterdonRegionalCancerCenter.org

NCI Community Oncology Research Program
A program of the National Cancer Institute of the National Institutes of Health

PATIENT QUESTIONNAIRE

Please bring completed to appointment with photo ID and insurance card(s)

Name: _____ Date of Birth: _____ Today's Date:_____

Height:_____ Weight:_____

Reason for visit:_____
_____
_____

Biopsy Date: _____ Facility (HMC, etc): _____
Surgery Date: _____ Facility: _____

Family Physician: _____ Medical Oncologist: _____
Surgeon: _____ Plastic Surgeon: _____

List any other physicians involved in your overall medical or cancer care (GI, Pulmonologist, etc): _____

Recent Imaging Studies (Please list approximate dates and facility):

☐ Mammogram	Date:_____ Facility:_____	☐ PET/CT	Date:_____ Facility:_____
☐ CT Scan	Date:_____ Facility:_____	☐ MRI	Date:_____ Facility:_____
☐ Other _____	Date:_____ Facility:_____	☐ Ultrasound	Date:_____ Facility:_____

Have you had:

A. Chemotherapy? No☐ Yes☐ If yes, last infusion Date: _____
Facility:_____ Physician:_____
Name of Chemotherapy_____

B. Hormone therapy? No☐ Yes☐ If yes, when did it start: _____
Facility:_____ Physician:_____

C. Radiation therapy? No☐ Yes☐ If yes, approx dates of treatment: _____
Area of body treated: _____
Facility:_____ Physician:_____

Name: _____

Please list:

Medical Conditions:	**Past Surgeries and Dates:**	
1.	1.	Date:
2.	2.	Date:
3.	3.	Date:
4.	4.	Date:
5.	5.	Date:

Family History (Blood Relatives):

A. Any family members with cancer history? No ☐ Yes ☐ If yes, please list relation and type of cancer:_____
_____
B. Father: ☐ Alive, Age____ or ☐ Deceased, Age___ cause_____
C. Mother: ☐ Alive, Age____ or ☐ Deceased, Age___ cause_____

Social History:

A. Occupation_____ Currently employed? No ☐ Yes ☐
B. Marital status: ☐ Married, ☐ Single, ☐ Widow/Widowed, ☐ Divorced, ☐ Significant Other
C. Children: No ☐ Yes ☐ If yes, how many and ages: _____
_____
D. Who do you live with?_____
E. Hobbies/interests_____
F. Do you drink alcohol? No ☐ Yes ☐ how many drinks per week? ____Type of alcohol_____ Do you drink caffeine? No ☐ Yes ☐
G. ☐ Never Smoked
☐ Active Smoker, How many packs of cigarettes per day? _____# of years_____
☐ Former Smoker, How many packs of cigarettes per day? _____
Quit how many years ago? _____
H. Any history of drug abuse/addiction? No ☐ Yes ☐ Type of drug_____
I. Autoimmune diseases? No ☐ Yes ☐ If yes, what type? _____
J. Inflammatory bowel disorders? No ☐ Yes ☐ If yes, what type? _____
K. Radon, asbestos, or other exposures? No ☐ Yes ☐ If yes, what type? _____
L. Assistive device/mobility: Cane ☐ Walker ☐ Wheelchair ☐
M. Do you have transportation? No ☐ Yes ☐

Do you have a living will? No ☐ Yes ☐ Do you have a durable power of attorney? No ☐ Yes ☐

If yes, please bring in a copy of your living will and power of attorney.

Name: _____

Do you CURRENTLY have any of the following conditions or symptoms (Check all that apply):

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain >10 lbs
- ☐ Weight Loss >10 lbs
- ☐ Chills
- ☐ Night Sweats
- ☐ Trouble Sleeping

SKIN
- ☐ History skin cancer
- ☐ Open wounds
- ☐ Nail changes
- ☐ New lesions
- ☐ Rash
- ☐ Skin color changes

HEENT
- ☐ Double vision
- ☐ Eye pain
- ☐ Decreased vision
- ☐ Decreased hearing
- ☐ Earache/ear ringing
- ☐ Nose bleeds
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Oral ulcers
- ☐ Sore throat
- ☐ Pain when swallowing

Date of last dental exam:_____

HEMATOLOGY
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Prolonged bleeding

PAIN

Do you have pain?
No☐ Yes☐
Location:_____
Describe:_____

RESPIRATORY
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Decreased exercise tolerance
- ☐ Difficulty breathing
- ☐ Coughing up blood
- ☐ Sputum production
- ☐ Wheezing

BREAST
- ☐ Breast mass
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Nipple inversion

Date of last mammogram:
_____

CARDIOVASCULAR
- ☐ Heart disease
- ☐ Chest pain
- ☐ Leg pains with walking
- ☐ Leg swelling
- ☐ Night awakening due to trouble breathing
- ☐ Palpitations
- ☐ Pacemaker/defibrillator

ENDOCRINE
- ☐ Appetite changes
- ☐ Cold intolerance
- ☐ Increased thirst
- ☐ Hair changes

Pain scale:
0 1 2 3 4 5 6 7 8 9 10

GENITOURINARY

Are you sexually active?
☐Y ☐N
- ☐ Difficulty starting/ stopping urinary stream
- ☐ Painful urination
- ☐ Change in urinary stream
- ☐ Increased frequency
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Nighttime urination
- ☐ Urinary retention

FEMALES ONLY
- ☐ Vaginal discharge
- ☐ Menstrual irregularities

Age of first period_____
Age of first pregnancy_____
Are you pregnant? ☐Y ☐N
Number of pregnancies____
Did you breast feed? ☐Y☐N
Did you ever take birth control?☐Y ☐N
Did you ever take hormone/fertility treatment?
☐Y ☐N
Date of last GYN exam:
_____
Date of last pap smear:
_____
Date of last menstruation:
_____
Date of menopause:
_____

Breast Cancer Patients
Bra size:_____

MALES ONLY
- ☐ Impotence
- ☐ Testicular pain
- ☐ Enlarged prostate
- ☐ Previous biopsy

MUSCULOSKELETAL
- ☐ Decreased range of motion
- ☐ Joint swelling
- ☐ Muscle aches/pains
- ☐ Back pain
- ☐ Bone pain
- ☐ Balance difficulty
- ☐ Fallen recently
- ☐ Weakness
- ☐ Arthritis

NEUROLOGICAL
- ☐ Loss of bowel control
- ☐ Dizziness/vertigo
- ☐ Headaches
- ☐ Numbness/tingling
- ☐ Passing out
- ☐ Seizures
- ☐ Tremor
- ☐ Memory problems

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Gastric reflux
- ☐ Rectal bleeding
- ☐ Trouble swallowing

Date of last colonoscopy:
_____

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal thoughts

Reviewed by: _____ Physician Signature: _____ Date: _____

Patient Medication List

Patient Name:	Date of Birth:
Primary Pharmacy:	Pharmacy Phone Number:

PLEASE LIST ALL OF YOUR ALLERGIES	TYPE OF REACTION

Please list all of your medications:
Prescription, over-the-counter medications, vitamins, **and** herbal supplements

NAME OF MEDICATION	DOSE	FREQUENCY