Virginia Cancer Specialists

DATE: _____

NAME: _____ _____ DOB:_____

What is the reason for your visit? _____

_____

_____

Date symptoms started? _____

Please list any treatments you've previously had for your current illness. (physical therapy, surgery, radiation etc.)

_____

_____

Other medical conditions:

ILLNESS	Yes or No	ILLNESS	Yes or No
Angina/ Cardiac Arrhythmias		Diabetes type	
Asthma		Elevated Cholesterol	
Bleeding Disorder		Fibromyalgia	
Blood Clots		Thyroid Disease	
Bronchitis		High blood pressure	
COPD		Kidney Disease	
Coronary Artery Disease		Liver Disease /Hepatitis	
Dementia/ Alzheimer's		Other	

If your answer is "yes," on any above question(s), please explain:

_____

_____

_____

SURGICAL HISTORY:

Surgical Procedure(s)	Date Performed

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MEDICATION:

Please list all medications, including prescriptions, over the counter medications and herbals that you are currently taking. Please include dosage and frequency.

Medication Name	Dosage	Frequency

Medication Allergies; if any:

_____

_____

OTHER:

Marital Status: _____ Occupation: _____

HABITS:

Substance	Do you use? Yes / No	What type?	How many per day?	How long?	If quit, when?
Tobacco					
Alcohol					
Caffeine					
Recreational Drugs					

FAMILY HISTORY: Please list any family members with a history of cancer with relation and age.

_____

_____

_____

PREVENTATIVE HEALTH MAINTENANCE: Please provide dates for each answer or write **"none"**

Last Mammogram:	Last Dexa /Bone Scan:
Last Colonoscopy:	Last Pneumonia Vaccine:

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REVIEW OF SYSTEMS: Please check any problem you have had in the last six months.

CONSTITUTIONAL:		**CARDIOVASCULAR:**	
Chills	Y / N	Angina (chest pain)	Y / N
Chills without fever	Y / N	Calf swelling	Y / N
Fatigue	Y / N	Chest pain, atypical	Y / N
Fever	Y / N	Dyspnea on exertion	Y / N
Intentional weight loss	Y / N	Hypertension (high blood pressure)	Y / N
Low energy level	Y / N	Hypotension (low blood pressure)	Y / N
Malaise	Y / N	Palpitation (irregular heart beat)	Y / N
Night sweats	Y / N	Peripheral edema lower-extremity (leg swelling)	Y / N
Sweats	Y / N		
Weight gain	Y / N	**RESPIRATORY:**	
Weight loss	Y / N	Asthma	Y / N
		Bronchitis	Y / N
EYES:		Cough	Y / N
Blurred Vision	Y / N	Dyspnea(difficult or labored breathing)	Y / N
Conjunctivitis	Y / N	Hemoptysis (coughing up blood)	Y / N
Corrective lens (glasses, contacts)	Y / N	Pneumonia	Y / N
Diplopia (double vision)	Y / N		
Excessive lacrimination (tearing)	Y / N	**GASTROINTESTINAL:**	
Eye pain	Y / N	Abdominal cramping	Y / N
Impaired Vision	Y / N	Abdominal pain	Y / N
Photophobia (extreme sensitive to light)	Y / N	Blood in stools	Y / N
Visual Changes	Y / N	Change in Bowel habits	Y / N
		Constipation	Y / N
GENITOURINARY:		Diarrhea	Y / N
Bladder spasm	Y / N	Distention (abdomen swelling)	Y / N
Burning on urination	Y / N	Dysphagia (difficulty swallowing)	Y / N
Cloudy urine	Y / N	Excessive thirst	Y / N
Dark urine	Y / N	Fecal incontinence	Y / N
Dysuria	Y / N	Heart Burn	Y / N
Flank pain	Y / N		
Hematuria	Y / N		
Nocturia	Y / N		
Urinary incontinence	Y / N		
Urinary retention	Y / N		
Urinary stone	Y / N		
Urinary tract infection	Y / N		
Urinary urgency	Y / N		

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MUSCULOSKELETAL:		**ENDOCRINE SYTEMS:**	
Arthralgias (joint pain)	Y / N	Cold intolerance	Y / N
Back pain	Y / N	Diabetes	Y / N
Bone pain	Y / N	Heat intolerance	Y / N
Carpal tunnel syndrome	Y / N	Hot flashes, menopausal	Y / N
Fracture	Y / N	Hot flashes, unrelated to menopause	Y / N
Low back pain	Y / N	Increase sweating	Y / N
Lymph edema	Y / N	Malaise	Y / N
Muscle weakness	Y / N	Polydipsia (excessive thirst)	Y / N
Neck pain	Y / N	Polyuria (excessive urination)	Y / N
Neck/back trauma (injury)	Y / N	Impaired dexterity (poor coordination)	Y / N
Sciatica	Y / N	Tremor	Y / N
Swollen joints	Y / N	Voice change	Y / N
SKIN:		**HEMATOLOGIC:**	
Change in nail appearance	Y / N	Anemia	Y / N
Change in pigmented lesion	Y / N	Bleeding disorder	Y / N
Dry skin	Y / N	Easy bruising	Y / N
Easy bleeding	Y / N	Ecchymosis	Y / N
Itching without rash	Y / N	Excessive bleeding on tooth extraction	Y / N
Non melanoma skin cancer hx	Y / N	Fatigue	Y / N
Photosentivity	Y / N	Frequent infections	Y / N
Pruritus(severe itching)	Y / N	Petechiae(small red or purple spot caused by bleeding into the skin	Y / N
Rash	Y / N	Prolonged bleeding	Y / N
NERVOUS SYSTEM:			
Blackout	Y / N		
Confusion	Y / N		
Diplopia (double vision)	Y / N		
Dizziness	Y / N		
Drowsiness	Y / N		
Falls	Y / N		
Gait changes (balance)	Y / N		
Headache	Y / N		
Impaired cognitive function	Y / N		
Involuntary movements	Y / N		
Lethargy	Y / N		

FOR OFFICE USE ONLY:

Weight: Height: BP: Pulse: Respiratory :
Advance Directives in writing: YES / NO Pain scale: Appetite: Normal or Decrease
Accompanied by:

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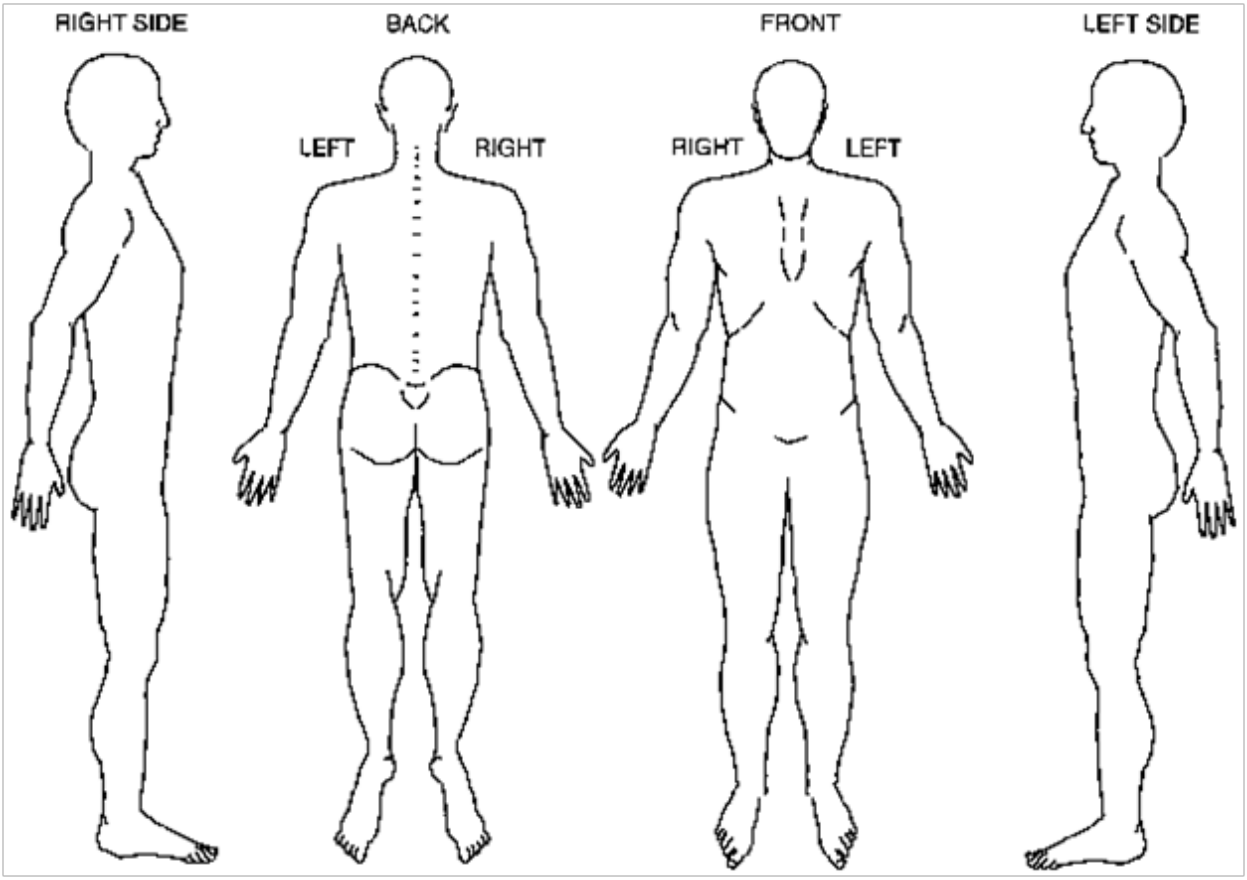
Your pain: Pain Diagram and Visual Analog Scale

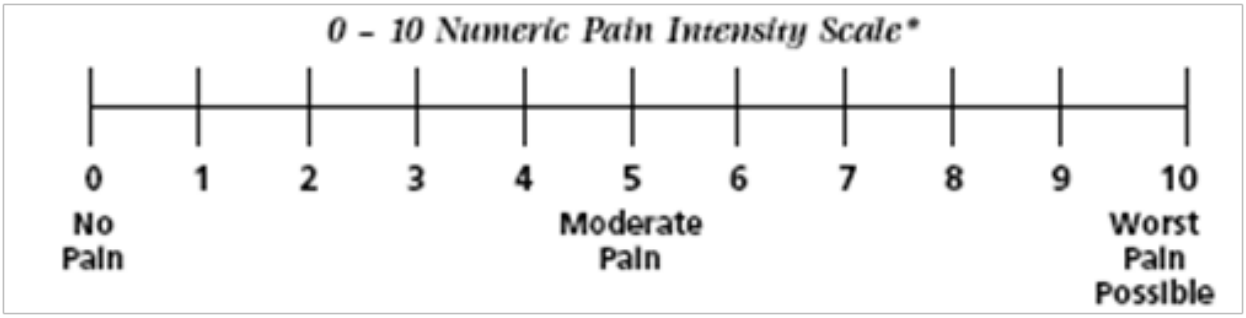
Mark the areas with the symbols on the diagram that matches your pain. Include all areas. If your pain spreads out, draw and (→) from where the pain starts.

ACHING: XXXX **NUMBNESS:** **** **PINS AND NEEDLES:** 0000

BURNING: >>>> **STABING:** //// **THROBBING**: ++++



For each area of pain, put a number beside it that matches your pain. The scale below describe the number your pain



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Previous Imaging Studies:

Test	Date
X-Ray	
CT	
MRI	
Bone Scan	
Other	

Preferred Pharmacy:

Pharmacy	Address	Phone #

Physicians:

Physicians	Phone/fax #
Referring MD:	
Primary Care:	
Orthopedic Surgeon:	
Medical Oncologist:	
Other:	

_____ _____

Patient Signature **Date**

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION IN THE FORM OF PHOTOGRAPH, VIDEOTAPE, AUDIOTAPE, OR OTHER MEDIA

The undersigned hereby authorizes Virginia Cancer Specialists and Felasfa Wodajo, MD to record me using photography, videotape, audiotape, and/or other media. This recording is for the purpose of clinical documentation and research. All attempts will be made to conceal any identifying features, such as my face, but I understand that it cannot be guaranteed.

The foregoing is subject to such limitations as indicated below:

I understand that I have the right to revoke this authorization at any time. I must do so in writing and present my written revocation to Virginia Cancer Specialists. I understand that the revocation will not apply to the information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this protected health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. Virginia Cancer Specialists is not responsible for any re-disclosure of the information provided.

_____ _____

Date **Signature of Patient (or Legal Representative*)**

_____

Printed Patient Name

_____

***Relationship/Authority of Legal Representative**