C.R. Wood Cancer Center
at GLENS FALLS HOSPITAL

Specializing in both Oncology and Hematology

Please complete the questions on the following pages as best as you can and bring this form to your appointment.

This information will help us to understand who you are and what we can do to assist you during this experience.

You will review this form with a Nurse who will be able to answer any questions or concerns that you have and assist you with any areas that may be difficult to answer.

There is a team of professionals available to you and we are interested in helping both you and those people who are important to your life. Please do not hesitate to ask questions and take advantage of the services available through the Cancer Center.

Thank you,

The Staff of the C.R. Wood Cancer Center

Please check in at the Cancer Center Reception Desk on the 1st floor in the Pruyn Pavilion. For questions please call 518-926-6620.

Patient Name: _____ **Date of Birth:** _____

Your Care Team:

Family Physician/PCP: _____

Surgeon: _____

Gynecologist: _____

Other: _____

_____

Do you have any Allergies? ☐ **yes** ☐ **no**

ALLERGIES	**What type of reaction do you have?**
_____	_____
_____	_____
_____	_____
_____	_____

Do you take any prescription or over the counter medication? ☐ **Yes** ☐ **No**

If yes, please list: **Please include herbs & vitamin supplements**

DRUG NAME	**DOSE**	**FREQUENCY**	**REASON**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List your past health history with dates (illness/problems, surgeries, injuries):

Illness or Problem/Date:	**Surgery/Date:**	**Injury/Date:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If applicable, please list date of last: **Colonoscopy:** _____

Mammogram: _____ **PAP Smear**: _____

Family History

Following is a list of questions regarding your family members. It is important for us to get as much information as possible, especially concerning any cancer or blood related problems in your family. List all family members, regardless of whether they have any health concerns. Please include any information that is known to you. For information that you are not sure of, it may be helpful to ask other family members. Please write unknown if you do not know the answer to a question. Remember, what may not seem important to you could be very important to us. (Examples of other conditions: high blood pressure, heart problems, breathing difficulties, seizures, mental retardation, stroke, eye problems, etc.)

Relative	Cancer or blood related problem (Answer Yes or No; what type? list all if more than one problem)	Age at Diagnosis	Other Illnesses or Medical Conditions** (Yes/No: what type of condition?)	Death (Yes/No) Cause & Age
Parents: Father Mother	_____ _____	_____ _____	_____ _____	_____ _____
Sisters: (names and ages) _____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
Brothers: (names and ages) _____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
Sons/Daughters: (names and ages) _____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
Grandparents, aunts, uncles, first cousins) (names and ages) _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____

Social History:

Do you currently smoke? ☐ Yes ☐ No If yes, how long have you smoked? _____ # years

Have you ever smoked? ☐ Yes ☐ no If yes, when did you stop? _____ # years ago

What do/did you smoke and how much per day?

cigarettes:	☐ yes ☐ no _____ per day	☐ currently
cigars:	☐ yes ☐ no _____ per day	☐ currently
pipe:	☐ yes ☐ no _____ per day	☐ currently
chew:	☐ yes ☐ no _____ per day	☐ currently

Do you drink alcohol (wine, beer or liquor)? ☐ Yes ☐ No

If yes, how often do you drink and how much do you drink?

☐ daily _____drinks ☐ weekly _____drinks ☐ occasional

Do you use recreational drugs? ☐ Yes ☐ No If yes, list _____

Do you have a history of drug or alcohol abuse? ☐ Yes ☐ No

Home/Environment:

Are you: ☐ married ☐ single ☐ divorced ☐ widow(er)

Do you live: ☐ alone ☐ with spouse ☐ with family ☐other _____

Do you have any type of homecare services that you use: ☐ yes ☐ no

If yes, please list: _____

Do you have any type of homecare equipment that you use: ☐ yes ☐ no

If yes, please list: _____

Do you need assistance with Activities of Daily Living ☐ yes ☐ no

Psychosocial:

Are there religious, spiritual, or cultural beliefs that are important to you? ☐ yes ☐ no

If yes, please explain: _____

Do you feel you have a lot of stress in your life? ☐ yes ☐ no

If yes, what things are causing stress for you? _____

Are you working: ☐ yes ☐ no ☐ retired

If **yes**: ☐ full time ☐ part time Where? _____

What is your occupation? _____

If **no**, do you plan to return to work? ☐ yes ☐ no ☐ unsure at present

Have you been exposed to hazardous materials? ☐ yes ☐ no
If yes, what type? _____
For how long? _____

Do you exercise on a regular basis? ☐ yes ☐ no
If yes, how often? ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5-6 times/week ☐ Daily
Activity ☐ Walking ☐ Aerobics ☐ Running ☐ Swimming ☐ Weight lifting ☐ Yoga
☐ Other: _____

Check if you have noticed a change in your energy level when:
☐ eating ☐ walking ☐ bathing ☐ doing housework
☐ shopping ☐ dressing ☐ cooking ☐ doing hobbies
Are any of these new? ☐ yes ☐ no If yes, which ones? _____

Check if you are experiencing any problem with sleep:
☐ difficulty falling asleep ☐ do not feel rested after sleeping
☐ difficulty staying awake ☐ usually feel rested after sleeping
☐ Other sleep related problems: _____
Describe / write a list of what helps you sleep: _____

Sexuality/Reproductive:

Are you sexually active? ☐ yes ☐ no

Are you and your partner currently any using birth control? ☐ yes ☐ no
If yes, what method? ☐ pills ☐ IUD ☐ condoms ☐ diaphragm ☐ patch ☐ rhythm
☐ Tubal ligation ☐ vasectomy ☐ other (specify) _____

Do you have any concerns about fertility preservation? ☐ yes ☐ no

Often people diagnosed with cancer have some concerns regarding sexual activity or sexuality; do you have any such concerns? ☐ No ☐ Yes (specify) _____

Female Specific:

Do you now or have you ever taken any Hormones such as estrogen, birth control pills or injections? ☐ yes ☐ no If yes, what type: _____ # of years used: _____

Do you have any of the following breast symptoms? If yes, please check:

☐ Fibrocystic Disease ☐ Tenderness ☐ Nipple Discharge ☐ Masses ☐ Other: _____

Do you know how to perform a self-breast exam? ☐ yes ☐ no

Do you perform breast self-exams? ☐ yes ☐ no

Would you like to learn how to perform a self-breast exam? ☐ yes ☐ no

Do you have any unusual vaginal discharge? ☐ yes ☐ no

Do you have any concerns about changes in your body? ☐ yes ☐ no

Number of Pregnancies _____ Number of Live Births _____ Age of first live birth: _____

Menstrual History:

Menstrual Status: ☐ Menopausal ☐ Post- Menopausal Last Menstrual Period: _____

Age of First Period: _____ Frequency: _____ Length: _____

Age of Last Period: _____

Description of Menstruation: ☐ Amenorrhea ☐ Dysmenorrhea ☐ Irregular ☐ Menopausal

☐ Missed periods ☐ Normal ☐ Post-menopausal ☐ Prior Abnormal ☐ Other: _____

Male Specific:

Have you had a vasectomy? ☐ yes ☐ no If yes, reason: _____

Do you have the any of the following symptoms? If yes, please check:

☐ History of infection ☐ Penile Discharge ☐ Penile Lesions

☐ Testicular Pain ☐ Testicular Swelling ☐ Other: _____

Do you perform self-testicular exams? ☐ yes ☐ no

Would you like to learn how to perform a self-testicular exam? ☐ yes ☐ no

Transfusion History:

Have you ever received a blood or blood product transfusion: ☐ Yes ☐ No

If yes, did you have an adverse reaction? ☐ Yes ☐ No

If yes, check type of reaction: ☐ Bloody Urine ☐ Chills ☐ Fainting/Dizziness ☐ Fever

☐ Flank Pain ☐ Hives ☐ Rash ☐ Other _____

Is a blood product transfusion acceptable to you if needed? ☐ Yes ☐ No

Are there any restrictions? ☐ Yes ☐ No If yes, list: _____

Do you have a history of bleeding problems: ☐ Yes ☐ No

If yes, list details: _____

Hematology History: **Complete only if you have had problems with blood clotting in the past**

Do you have a history of clotting problems: ☐ Yes ☐ No

If yes, list details: _____

Do you think you have a tendency to develop abnormal blood clots: ☐ Yes ☐ No

If yes, when did this begin _____

Please describe the circumstances: _____

_____

Have you had any of the following prior to developing a clot: ☐ Surgery/Procedure ☐ Trauma

☐ Hospitalized ☐ Pregnancy ☐ Oral Contraceptive Use ☐ Estrogen Replacement Use

☐ Cancer ☐ Air Travel ☐ Car trip over 4 hours ☐ Bed rest longer than 4 days

Long Term effects of blood clots:☐ Leg pain at rest ☐ Leg pain w/walking ☐ Leg cramps at rest

☐ Leg cramps w/walking ☐ Leg swelling ☐ Leg swelling that varies by time of day

☐ Discoloration of legs ☐ Leg ulcers ☐ Limitations in: recreational activities, work or self-care

Check if you are experiencing any of the following:
Respiratory: ☐ Shortness of Breath ☐ Cough
Comment: _____
Cardiovascular: ☐ Chest Pain ☐ Palpitations ☐ Dizziness ☐ Swelling
Comment: _____
Gastrointestinal: ☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea
☐ Bloating ☐ Blood in Stool ☐ Hemorrhoids ☐ Up at night to go
Date of your last Bowel Movement: _____
Comment: _____
Genitourinary: ☐ Dribbling ☐ Burning ☐ Pain ☐ Trouble starting to go ☐ Frequency
☐ Blood in urine ☐ No control ☐ Up at night to go (# of times _____)
Skin: ☐ Bruising ☐ Change in skin color ☐ Itching ☐ Rash ☐ Lesion
Comment: _____
Neurological: ☐ Hearing ☐ Seizures ☐ Smell ☐ Speech ☐ Confusion/Disorientation
☐ Dizziness ☐ Drowsiness ☐ Faintness ☐ Headache ☐ Numbness ☐ Tingling
☐ Visual changes ☐ Weakness ☐ Other
Comment: _____
Neuromuscular: ☐ Joint Stiffness ☐ Joint Swelling ☐ Numbness ☐ Tingling ☐ Weakness
☐ Other Comment: _____
Do you have a **Central Venous Access Line**: ☐ Yes ☐ No
If yes, list type, location and insertion date: _____

Have you ever been treated with radiation therapy? ☐ Yes ☐ No If yes, please describe: _____
_____
Are you currently using any methods of cancer treatment? ☐ Yes ☐ No If yes, what methods?
_____

Do you have a prescription plan? ☐ Yes ☐ No If yes, who is your plan with? _____

Dental Health: Who is your dentist? _____ When was your last dental exam? _____
Do you have any loose teeth? ☐ Yes ☐ No
Do you have dentures? ☐ Yes ☐ No If yes: ☐ Upper ☐ Lower ☐ Partial
Are you having any dental problems? ☐ Yes ☐ No If yes, list: _____

Diet and Nutrition:
Have you had any weight change in the last 3 months? ☐ Yes ☐ No
If yes, number of pounds _____ ☐ lost ☐ gained
Check the word(s) that describe your diet:
¨ regular ¨ liquid ¨soft ¨diabetic ¨ pureed ¨ other _____
Check if you are experiencing any of the following: ☐ Loss of appetite ☐ Nausea ☐ Vomiting
☐ Metallic taste ☐ Indigestion ☐ Mouth sores ☐ Difficulty swallowing ☐ Difficulty chewing
☐ Other: _____
Are any of these new? ☐ Yes ☐ No
If yes, which ones? ☐ Loss of appetite ☐ Nausea ☐ Vomiting ☐ Metallic taste ☐ Indigestion
☐ Mouth sores ☐ Difficulty swallowing ☐ Difficulty chewing ☐ Other

Sensory:
Do you wear: ☐ Glasses ☐ Contacts ☐ Hearing Aid(s)
Do you have a history of: ☐ Cataracts ☐ Glaucoma ☐ Other_____
Who is your eye doctor: _____ Date of last eye exam: _____

Psychosocial:
Do you feel like you have a lot of stress in your life? ☐ Yes ☐ No
In the last year, have there been any major events in your life besides your illness? ☐ Yes ☐ No
If yes, please explain: _____
Are you currently seeing a counselor or psychologist? ☐ Yes ☐ No
If yes, who are you working with: _____
Are you interested in talking with a counselor for support or help coping with your illness?
☐ Yes ☐ No
Is anyone in your family interested in speaking with a counselor? ☐ Yes ☐ No
Have you had experience with cancer in the past? ☐ Yes ☐ No
What concerns you most about your health problem? _____

Do you have an Advanced Directive? ☐ Yes ☐ No Date Signed: _____
If yes, what type: ☐ Durable Power of Attorney ☐ Health Care Proxy ☐ Living Will
☐ Extended Care Facility DNR ☐ Nonhospital DNR ☐ MOLST ☐ Other _____
What is the name of Power of Attorney or Health Care Proxy? _____
**** Please bring a copy with you if it is not already on file at Glens Falls Hospital****
If you do not have an Advanced Directive, would you like information about it? ☐ Yes ☐ No

Fall Risk:
Have you fallen 2 or more times in the last 12 months? ☐ Yes ☐ No
If yes, were you injured? ☐ Yes ☐ No Please explain: _____

Patient Signature: _____ **Date**: _____

Nurse Signature: _____ **Date:** _____