



North Star Lodge Cancer Center  
808 N 39<sup>th</sup> Ave Yakima, WA 98902 (509) 574-3400

## Patient Information Summary

This information will remain confidential unless you authorize its release.

Name \_\_\_\_\_ Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Reason for your visit to North Star Lodge? \_\_\_\_\_

What doctors have you seen? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referred by: \_\_\_\_\_

Have you had X-rays or Scans? When and Where \_\_\_\_\_

\_\_\_\_\_ Have you been hospitalized in the past? Reason(s) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Have you had surgery in the past? Type and year \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Personal Health History

Have you had any of the following? If yes, please explain:

\_\_\_\_\_ Allergy \_\_\_\_\_

\_\_\_\_\_ Anemia \_\_\_\_\_

\_\_\_\_\_ Arthritis \_\_\_\_\_

\_\_\_\_\_ Asthma \_\_\_\_\_

\_\_\_\_\_ Cancer \_\_\_\_\_

\_\_\_\_\_ Depression \_\_\_\_\_

\_\_\_\_\_ Diabetes \_\_\_\_\_

\_\_\_\_\_ Emphysema \_\_\_\_\_

\_\_\_\_\_ Heart Disease or a heart murmur \_\_\_\_\_

\_\_\_\_\_ Hepatitis or Yellow Jaundice \_\_\_\_\_

\_\_\_\_\_ High blood pressure \_\_\_\_\_

\_\_\_\_\_ Kidney stones \_\_\_\_\_

\_\_\_\_\_ Liver disease \_\_\_\_\_

\_\_\_\_\_ Low Back pain \_\_\_\_\_

\_\_\_\_\_ Migraine \_\_\_\_\_

\_\_\_\_\_ Seizures \_\_\_\_\_

\_\_\_\_\_ Tuberculosis \_\_\_\_\_

\_\_\_\_\_ Other Medical Conditions \_\_\_\_\_

**Personal Health History** cont.

Are you taking prescription medications? If yes, please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Over the counter medications? \_\_\_\_\_

\_\_\_\_\_

Vitamins, minerals, herbals or supplements? \_\_\_\_\_

\_\_\_\_\_

Do you have allergies or bad reactions to any medications?

Name of Medication

What happens when you take it?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your pharmacy of choice? \_\_\_\_\_

\_\_\_\_\_

**Family History**

If any of the following apply, please explain.

If alive, is your father ill with any disease process or cancer? List \_\_\_\_\_

Age and cause of death, if deceased \_\_\_\_\_

If alive, is your mother ill with any disease process or cancer? List \_\_\_\_\_

Age and cause of death is deceased \_\_\_\_\_

Do you have sisters and brothers? \_\_\_\_\_

Their ages and health \_\_\_\_\_

\_\_\_\_\_

Do you have children? \_\_\_\_\_

How many? \_\_\_\_\_ Ages and Health \_\_\_\_\_

Are there diseases that run in the family? Name \_\_\_\_\_

**Social History**

What is your age? \_\_\_\_\_

Marital Status: S \_\_\_\_ M \_\_\_\_ W \_\_\_\_ Div \_\_\_\_ Sep \_\_\_\_

Where do you live (town)? \_\_\_\_\_

Current/Prior Occupation \_\_\_\_\_

Are you working?  Full Time  Part Time  No-Retired  Student

If no, do you plan to return to work? \_\_\_\_\_

Educational Experience  High School  College  Post Grad

What are your main hobbies or interests? \_\_\_\_\_

Check if any of the following apply, please explain, in the last year have you experienced any of the following?

**Smoking History**

Never smoked

Smoke  How much  How long

Quit  Date Quit

**Alcohol Consumption**

Frequency Amount Beer Wine Liquor

Less than once a week

2-4 times a week

Nearly every day

None

Marriage

Divorce or Separation

Major illness or death in family

Personal illness or injury

Gain a new family member

Change in job or home

Do you have any religious/cultural beliefs/needs that we should be aware of during your treatment?

Check in any of the following apply.

Yes  No  Do you support yourself by full time employment?

Yes  No  Do you collect Social Security?

Yes  No  Do you support yourself with public assistance?

Yes  No  Do you have other means of support? Explain \_\_\_\_\_

Yes  No  Do you live in your own home?

Yes  No  Do you live in an apartment?

Yes  No  Other living accommodations? Explain \_\_\_\_\_

Yes  No  Are you safe in your home? If not, Why \_\_\_\_\_

Yes  No  Are you anticipation needing help at home? \_\_\_\_\_

Yes  No  Do you have difficulty walking? Why \_\_\_\_\_

Yes  No  Do you have a living will? If yes, please bring a copy with you if available.

Yes  No  Do you have a Durable Power of Attorney? If yes, please bring a copy with you if available.

Yes  No  Are you or your family member (s) interested in a support group? What type \_\_\_\_\_

Yes  No  Do you have questions regarding your dietary needs?

Indicate any of the following services you are using:

Home Care

Sick Benefits

Social Work

Oxygen Therapy

Cancer Society

Physical Therapy

Disability

Welfare

Unemployment insurance

Other \_\_\_\_\_

## REVIEW OF SYSTEMS

Check if any of the following apply. Please Explain

### GENERAL

- Recent Weight Loss Pounds \_\_\_\_\_
- Recent Weight Gain Pounds \_\_\_\_\_
- Night Sweats
- Fevers
- Fainting episodes or blackouts
- Loss of appetite
- Swollen ankles
- Skin Problems
- Increase in thirst
- New lumps in skin or armpits
- Fatigue, lack of energy
- Difficulty sleeping
- Muscle weakness
- Use walker/cane/wheelchair
- Pain  
Where? \_\_\_\_\_

Do you understand how to manage your pain? Yes \_\_\_ No \_\_\_

Would you be interested in a exercise program? Yes \_\_\_ No \_\_\_

Do you have and dental concerns? Yes \_\_\_ No \_\_\_

### FEMALES

- Breast Lumps
- Unusual vaginal bleeding
- Vaginal discharge
- Sexual problems
- Regular periods
- Date of last pap smear \_\_\_\_\_
- Dat of last mammogram \_\_\_\_\_
- Age at 1<sup>st</sup> menstrual period \_\_\_\_\_
- How many pregnancies \_\_\_\_\_
- Age at 1<sup>st</sup> Childbirth \_\_\_\_\_
- How many Children \_\_\_\_\_
- Age at menopause \_\_\_\_\_

Do you perform monthly breast exams?  
Yes \_\_\_ No \_\_\_

### NERVOUS SYSTEM

- Headaches
- Blurred or double vision
- Seizures
- Diminished hearing
- Difficulty with speech
- Numbness, tingling
- Weakness of an arm or leg
- Balance problems
- History of falling
- Memory trouble
- Panic attacks
- Anxiety
- Excessive worry
- Crying spells
- Feeling of worthlessness
- Depression

### HEART-CIRCULATION

- Have a heart murmur
- Chest pain at rest
- Chest pain with walking or exercise
- Frequent irregular heart beat
- Need to sit up to breathe at night
- Get pain in thighs or calves that goes away when you stop walking

### LUNGS

- Chronic cough
- Coughing up blood
- Pain with breathing
- Wheezing
- Shortness of breath

### HEAD, EYES, EARS, NOSE, THROAT

- Hoarseness, recent or lasting longer than 2 wks
- Frequent bleeding gums
- Frequent nosebleeds
- Hay fever

### STOMACHE, INTESTINAL

- Difficulty swallowing
  - On tube feeding/TPN
  - Frequent heartburn
  - Known ulcer
  - Frequent stomach pain
  - Nausea and vomiting
  - Gallstones
  - Diarrhea
  - Black or tarry BM'S
  - Red blood in BM'S
  - Mucous in BM'S
  - Constipation
  - Have an ostomy
- One or two normal BM'S nearly every day? Yes \_\_\_ No \_\_\_

### URINARY

- Have frequent urinary tract infections
- Burning with urination
- Have to urinate every hour
- Loose your urine when coughing or excited
- Blood in urine
- Trouble starting urination
- Urge to urinate, but pass only small amount
- Frequency of urination at night

Patient Signature \_\_\_\_\_