Cancer Center

North Star Lodge Cancer Center
808 N 39th 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 mammorgram ____
Age at 1st menstrual period ____
How many pregnancies ____
Age at 1st 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 _____