Banner MD Anderson Cancer Center
Making Cancer History®

PATIENT HISTORY DATABASE

PLEASE fill in WHITE AREAS, FRONT AND BACK OF ALL PAGES, BEFORE YOUR APPOINTMENT. Your answers will help the staff plan and provide your care, as well as help us with our research to better understand the risk factors for cancer. Leave blank any parts you are unsure of, or do not wish to answer. We will review the form with you. **Any information we gather will be kept confidential.** PRINT AND USE INK. Thank you.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Person completing the form if not the patient: _____ Relationship to patient: _____

PRIMARY LANGUAGE: ❑ English ❑ Spanish ❑ Other _____ ❑ Used Certified Translator

CURRENT MEDICAL HISTORY:

What is your medical reason for coming to Banner M.D. Anderson? (Chief Complaint):

_____

Please give the history of your current problem: (when it started; symptoms; treatment): _____

_____

_____.

Are you **ALLERGIC** to anything? ❑ Yes ❑ No

List all ALLERGIES and describe your reaction.

_____

PAST MEDICAL HISTORY: Please check **ALL** previous illnesses or conditions below.

❑ Bleeding problems	❑ High blood pressure	❑ Psychological/Psychiatric problems	
❑ Circulation problems	❑ HIV/AIDS	❑ Seizure	
❑ Diabetes or sugar in urine	❑ Kidney/urine problems	❑ Stroke	
❑ Frequent infections	❑ Liver problems	❑ Thyroid problems	
❑ Heart problems	❑ Lung problems	❑ Tuberculosis	❑ Other _____

Please provide more information below for any of the conditions or illnesses you checked above: _____

_____.

Notes:

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Please complete the **TABLE** below for my **PRIOR** cancer, radiation treatment, or chemotherapy that you may have had:

	Don't know	No	Yes	Year	Kind of cancer or Type of disease / condition
Prior Cancers (before current illness):					
Prior Radiation Treatment (not dental x-rays or for broken bones):					
Prior Chemotherapy:					

Past Hospitalization (include reason and date): _____

Past Surgeries (include type of surgery and date): _____

Do you have any problems with: ❑ Hearing ❑ Vision

CURRENT MEDICATIONS (include prescription, over-the-counter and herbals):

NAME OF MEDICINE	DOSE	HOW OFTEN TAKEN	TIME LAST TAKEN	REASON FOR TAKING	LENGTH OF TIME

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REVIEW OF SYSTEMS: **Check all the following problems that you are** HAVING NOW:	**INTERVIEW**	**PHYSICAL EXAM**
GENERAL: ❑ NONE ❑ OTHER ❑ fever-chills ❑ sweats ❑ change in sleep habits ❑ fatigue ❑ weight gain ❑ weight loss ❑ pain - location _____		
NEUROLOGICAL: ❑ NONE ❑ OTHER ❑ memory changes ❑ numbness/tingling ❑ dizziness/fainting ❑ weakness ❑ blurred vision ❑ headache ❑ hearing difficulty ❑ ringing ears ❑ seizures ❑ speech changes ❑ unbalanced walking		
HEAD & NECK: ❑ NONE ❑ OTHER ❑ nose bleeds ❑ hoarseness ❑ sores in mouth or ❑ throat sore throat		
BREAST: ❑ NONE ❑ OTHER ❑ changes ❑ lumps ❑ nipple discharge date of last mammogram:		
CARDIOVASCULAR: ❑ NONE ❑ OTHER ❑ leg pain/swelling ❑ chest pain ❑ fast heart beat		
RESPIRATORY: ❑ NONE ❑ OTHER ❑ wheezing ❑ cough ❑ short of breath ❑ bloody phlegm/sputum		

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REVIEW OF SYSTEMS: **Check all the following problems**	**INTERVIEW**	**PHYSICAL EXAM**
GASTROINTESTINAL: ❑ NONE ❑ OTHER ❑ yellow skin or eyes ❑ nausea/vomiting ❑ problems swallowing ❑ cramping/stomach pain ❑ change in appetite/diet ❑ indigestion ❑ reflux - diarrhea ❑ constipation ❑ black stools ❑ blood in stools		
GENITOURINARY: ❑ NO ❑ OTHER ❑ burning ❑ frequency ❑ blood in urine ❑ dribbling ❑ unable to control bladder		
MUSCULOSKELETAL: ❑ NONE ❑ OTHER ❑ joint swelling ❑ joint/back pain ❑ stiffness ❑ trauma ❑ falls		
SKIN: ❑ NONE ❑ OTHER ❑ open sore ❑ change in moles ❑ abnormal ❑ color rashes		
ENDOCRINE: ❑ NONE ❑ OTHER ❑ cold intolerance ❑ hot flashes		
HEMATOLOGY/LYMPH: ❑ NONE ❑ OTHER ❑ abnormal bleeding ❑ prior transfusion ❑ easy bruising ❑ swelling in groin/armpit/neck		

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REVIEW OF SYSTEMS: **Check all the following problems**	**INTERVIEW**	**PHYSICAL EXAM**
PSYCHOLOGICAL: ❑ NONE ❑ OTHER ❑ worried/anxious ❑ sad/depressed		
FEMALE ONLY: ❑ NONE ❑ OTHER ❑ unusual bleeding/discharge last menstrual period: last pap smear: Birth Control: ❑ Yes ❑ No		
MALE ONLY: ❑ NONE ❑ OTHER ❑ problems with passing urine ❑ enlarged prostate date of last prostate exam		

GENERAL HEALTH: In general, would yo say your health is:
❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor

Does your health now limit you in any of the following activities?

	Limited a lot	**Limited a little**	**Not limited at all**
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf			
Climbing several flights of stairs			

During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of....

Your physical health?

	Yes	**No**
Accomplish less than you would like		
Was limited in the kind of work or other activities.		

Any emotional problems (such as feeling depressed or anxious)

	Yes	**No**
Accomplish less than you would like		
Didn't do work or other activities as carefully as usual		

During the past four weeks, have you been feeling:

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Calm and peaceful?						
Had a lot of energy?						
Downhearted and blue?						

During the past four weeks, how much of the time has your Physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
❑ All of the time ❑ Most of the time ❑ Some of the time ❑ A little of the time ❑ None of the time

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WORK HISTORY:

What job have you held for the longest period of time (can include homemaker / student) _____

What type of tools, equipment or chemicals did you use on that job? _____

What kind of company did you work for on that job?
How many years did you do that type of work? _____ What is your current Occupation?
Are you currently able to work? ❑ Yes ❑ No ❑ Not applicable

DEMOGRAPHIC INFORMATION:

Religion raised in: ❑ Protestant ❑ Catholic ❑ Jewish ❑ Muslim/Islam ❑ Mormon/Latter Day Saints
❑ None ❑ Other (specify) Current Religion _____

Race / Ethnicity: ❑ White, Anglo, Caucasian ❑ Spanish Origin (Hispanic) ❑ Black (African American)
❑ Asian/Pacific Islander ❑ Am. Indian/Native American ❑ Other (Specify) _____

Education: (highest grade completed) ❑ Less than 8th grade ❑ 9-11th grade ❑ High School graduate ❑ Vocational/Technical school ❑ Associate degree/some college ❑ Bachelor's degree ❑ Advanced degree ❑ Other (specify) _____

If still in school, what is your current grade? _____ Are you home schooled due to illness? ❑ Yes ❑ No ❑ Sometimes ❑ N/A In

what Country were you born? _____ In what Country have you lived the longest? _____

FAMILY HISTORY:

Are you Adopted? ❑ No ❑ Yes Are you a Twin? ❑ No ❑ Yes What type of twin? ❑ Identical ❑ Fraternal ❑ Don't know
Excluding yourself, how many of each of the following blood-related family members do you have? **Remember to include those who are no longer living.** Include only **full** brothers or sisters. Brothers____ Sisters____ Sons____ Daughters_____

Complete the table below for each of your blood relatives who has had cancer. Identify relative type by writing in mother, son, sister, grandfather, aunt, etc. If it is a grandparent, aunt or uncle, place in the box an "F" after the relative if from your **father's side** or an "M" if from your **mother's side** of the family.
You can write in an approximate age for diagnosis or age died.

Relative Type		Year Born	Still Yes	Living No	Age Died?	Ever Yes	Smoked No	Kind/location of Cancer	Age Diagnosed

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ALCOHOL HISTORY:

Do you drink alcoholic beverages regularly (at least 1 drink per month)? ❑ Yes, currently ❑ Yes, but quit ❑ Never/rarely

Beverage	Number of Drinks per			
Beer (12 oz can/bottle)	Day	Week	Month	Year
Wine (4 oz glass)				
Liquor (1 shot or jagger)				

If you have quit drinking, how old were you when you quit? _____ Years old

TOBACCO HISTORY:

Have you ever smoked at least 100 cigarettes (5 packs) during your lifetime?
❑ Yes, currently smoke ❑ Yes, but quit smoking ❑ No

How soon after you wake up, do/did you smoke your first cigarette?
❑ 30 minutes or less after waking ❑ more than 30 minutes after waking

How old were you when you first started smoking cigarettes regularly?_____years old

On average, how many cigarettes do/did you smoke per day?_____

If you quit, how old were you when you quit?_____

Have you ever used any of the following tobacco products?

	Yes	No	Quit	Year Quit	Amount/Day	Years Used
Chewing Tobacco						
Snuff or Dip						
Pipes						
Cigars						

Have you ever used any recreational (street drugs)? ❑ Yes, currently ❑ Yes, in the past ❑ Never

PAIN ASSESSMENT

1. Have you experienced pain in the last week?
   ❑ No (Stop here) ❑ Yes (Answer remaining questions to describe your pain)
2. Are you taking medication for the pain?
   ❑ No ❑ Yes, what is the name of the pain medication? _____
3. List the locations of your pain _____
4. Circle the number that best describes the amount of pain you are having. (How strong is the pain?)
   0 1 2 3 4 5 6 7 8 9 10
   No pain — Worst pain imaginable
5. At what pain level would you be comfortable?
   0 1 2 3 4 5 6 7 8 9 10
   No pain — Worst pain imaginable
6. How much does your pain interfere with your daily activities?
   0 1 2 3 4 5 6 7 8 9 10
   Not At All — Completely
7. What makes the pain better? _____
8. What makes the pain worse? _____

Reviewed by Physician _____ Date/Time _____

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