Lawrence Cancer Center
330 Arkansas Street, Suite 120
Lawrence, KS 66044-1485
(785) 749-3600
fax (785) 749-3621
www.lawrencecancercenter.com

Today's Date: _____

I. PATIENT DEMOGRAPHICS:

Last: _____ First: _____ Middle: _____

Gender: Male / Female Date of Birth: _____ Age: _____ Height: _____

Race (please circle one): American Indian/Alaska Native Asian Black/African American

Native Hawaiian/Other Pacific Islander White

Ethnicity (circle one): Hispanic/Latino or Not Hispanic/Not Latino **Language**: _____

SSN: _____ Marital Status: S M W D Children: Y N How Many: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Contact Preference (please circle one): Home Phone Cell Phone Work Phone

Occupation: _____ Highest Level of Education: _____

Employed: Full time / Part time Disabled: Y N If Yes, Full / Partial Date: _____

Are you able to Drive yourself? **YES NO** If NO, Do you have available Transportation? **YES NO**

Email: _____

Pharmacy: _____ Location: _____

Home Care / Hospice / Nursing Facility: Y N Facility Name: _____

Address: _____

Primary Care Doctor: _____ Medical Oncologist: _____

Surgeon(s): _____ Referring Physician: _____

Other Physicians Involved in your Cancer Care: _____

REASON FOR TODAY'S VISIT: _____

Who Has Accompanied You Today? _____

PATIENT NAME: _____

II. HISTORY OF PRESENT ILLNESS:

CANCER – WHAT TYPE (S)? _____

DIAGNOSIS DATE(S): _____

HAVE YOU EVER RECEIVED CHEMOTHERAPY OR RADIATION THERAPY? YES NO

MOST RECENT DATE RECEIVED: _____ TYPE: _____

MOST RECENT DATE RECEIVED: _____ TYPE: _____

III. MEDICAL & SURGICAL HISTORY: *(PLEASE CIRCLE ALL THAT APPLY TO YOU)*

AUTOIMMUNE DISORDERS	DIVERTICULITIS	HIGH CHOLESTROL	OSTEOARTHRITIS
BLOOD DISORDERS	HEARING LOSS	HIV/AIDS	PACE MAKER
CATARACTS/GLAUCOMA	HEART	JAUNDICE/CIRRHOSIS	SEIZURES
CIRCULATION PROBLEMS	DISEASE/PROCEDURE	KIDNEY DISEASE	SKIN CANCER
COLON POLYPS	HEMORRHOIDS	LUNG DISORDERS	STROKE
DEPRESSION	HERNIAS	MELANOMA	SUNBURNS: EST # _____
DIABETES	HIGH BLOOD PRESSURE	MIGRAINES	THYROID DISEASE

PLEASE LIST ANY OTHER SERIOUS ILLNESSES/DISEASES, INJURIES/ACCIDENTS, SURGERIES/PROCEDURES THAT REQUIRED HOSPITALIZATION OR TREATMENT:

DATE (MONTH/YEAR):	SURGERIES OR HOSPITALIZATION:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IV. GYN HISTORY: **<u>FEMALE PATIENTS ONLY</u>**

ARE YOU OR COULD YOU BE PREGNANT? **YES NO**

AGE AT FIRST MENSTRUAL PERIOD: _____ DATE OF LAST MENSTRUAL PERIOD: _____

DATE OF LAST MAMMOGRAM: _____ DATE OF LAST PAP SMEAR: _____

HAVE YOU EVER USED ESTROGEN: **YES NO** HOW MANY YEARS? _____

BIRTH CONTROL PILL USE: **YES NO** HOW MANY YEARS? _____

NUMBER OF PREGNANCIES: _____ AGE AT FIRST PREGNANCY: _____

NUMBER OF CHILDREN: _____ ADOPTED CHILDREN: _____

DID YOU BREAST FEED YOUR CHILDREN? **YES NO**

PAST SURGERY ON BREASTS? **YES NO** IF YES, WHAT TYPE? _____

HYSTERECTOMY? **YES NO** IF YES, WHEN? _____

PATIENT NAME: _____

V. MEDICATIONS - ATTACH LIST IF AVAILABLE - (INCLUDE VITAMINS, SUPPLEMENTS & ALTERNATIVE MEDICINES):

MEDICATION NAME: DOSE: HOW OFTEN:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

VI. ALLERGIES:

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS, IODINE CONTRAST, OR SHELLFISH? **YES NO**

If yes, please list medications and the type of reaction: _____

_____

VII. FAMILY HISTORY OF HEALTH PROBLEMS: ARE YOU ADOPTED? YES NO
(IF YES, PLEASE SKIP TO THE NEXT SECTION).

IN THE SPACES PROVIDED PLEASE INDICATE IF ANY OF YOUR FAMILY MEMBERS HAVE OR DID HAVE A HISTORY OF HEALTH PROBLEMS SUCH AS **CANCER**, HEART PROBLEMS, HIGH BLOOD PRESSURE, DIABETES, ETC. **(**IT IS NOT NECESSARY TO LIST THEIR NAMES**)**

	LIVING STATUS (ALIVE/DECEASED)	**AGE** (ALIVE/ DECEASED)	**MEDICAL HISTORY**	**CANCER HISTORY**
MOTHER				
FATHER				
SIBLINGS (Brothers/Sisters)				
OTHER RELATIVES				

PATIENT NAME: _____

VIII. SOCIAL HISTORY:

SMOKING STATUS: SMOKER / NON-SMOKER **HAVE YOU SMOKED IN THE PAST**: Y N

PAST TOBACCO USAGE: Years of Usage: _____ Pack(s) per Day: _____ Quit date: _____

DO YOU USE ALCOHOL? **YES NO** FREQUENCY & AMOUNT OF USE: _____

IN THE PAST YEAR HAVE YOU HAD YOUR FLU SHOT? YES NO **PNEUMONIA SHOT?** YES NO

Occupation: _____ Highest Level of Education: _____

Employed: Full time / Part time Disabled: Y N If Yes, Full / Partial Date: _____

DO YOU EXERCISE ROUTINELY? **YES NO**

If so, what Activity?_____ How Long & How Often? _____

Children (List Gender/Age): _____

Who Lives with You? _____

IX. REVIEW OF SYSTEMS – (refer to the ROS Checklist on the next page)

CURRENT SYMPTOMS: Are you experiencing any pain now? **Yes No** Location:_____

(no pain) (some pain) (very painful)

LEVEL OF PAIN: 0 1 2 3 4 5 6 7 8 9 10

LAST DENTAL EXAM: (Date) **_____** **Dentist: _____**