THE UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER

Patient History Database

Institutional

Patient **MDA #**
ACCT# **Print Date**
DOB **FC** **SEX** **Location**

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.

PERSON COMPLETING THIS FORM: ______________________________

☐ PATIENT ☐ OTHER (Indicate Relationship to Patient) ______________________________

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other ______________________________ ☐ Used Certified Translator

CURRENT MEDICAL HISTORY:

What is your medical reason for coming to 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
☐ Circulation problems
☐ Diabetes or sugar in urine
☐ Frequent infections
☐ Heart problems
☐ High blood pressure
☐ HIV/AIDS
☐ Kidney/urine problems
☐ Liver problems
☐ Lung problems
☐ Psychological/Psychiatric problems
☐ Seizure
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ Other ______________

Please provide more information below for any of the conditions or illnesses you checked above. ______________________________

Patient, please DO NOT write in this space.

DATE:______________ TIME:______________

Measured **height** (cm): ______________

Measured **weight** (kg): ______________

Usual weight before DX/TX (kg): ______________

Last date at usual weight: ______________

Head Circumference if < 2 years of age: ______________

Vital signs: T ______________ P ______________

R ______________ B/P ______________

Current Pain Level (0-10): ______________

Literate: ☐ Yes ☐ No

Immunizations < 12 years current? ☐ Y es ☐ No

Copy provided? ☐ Yes ☐ No

Patient, DO NOT write in this space.
(History of present illness, previous cancer treatment)

Healthcare Member Signature / Title / Date

IF ADDITIONAL SPACE REQUIRED USE LAST PAGE

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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 Hospitalizations (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 TAKEN

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TO BE COMPLETED BY PATIENT

REVIEW OF SYSTEMS:
Check all the following problems that you are HAVING NOW:

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
- ☐ nosebleeds
- ☐ 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

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

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TO BE COMPLETED BY CLINICAL TEAM

INTERVIEW	PHYSICAL EXAM

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TO BE COMPLETED BY PATIENT

TO BE COMPLETED BY CLINICAL TEAM

REVIEW OF SYSTEMS: Check all the following problems that you are **HAVING NOW:**	INTERVIEW	PHYSICAL EXAM
GENITOURINARY; ☐ NONE ☐ 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		
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 ________		

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MD ANDERSON
CANCER CENTER

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FC
SEX
Location
MDA #

GENERAL HEALTH:

In general, would you 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

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 ☐ Moslem/Islarn ☐ 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 ☐ Vocational/technical school ☐ Advanced degree ☐ 9- 11th grade ☐ Associate degree/some college ☐ Other (Specify) ____________________ ☐ High school graduate ☐ Bachelor's degree

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?** ____________________

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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 a "F" after the relative if from your **father's side** or a "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 living		Age Died?	Ever smoked Yes	Ever smoked No	Kind/location of cancer	Age Diagnosed

ALCOHOL HISTORY:

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

Complete the table below if you checked EITHER Yes box to the alcohol question above:

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

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

GO TO * BELOW

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? __________ Number per day

If you have quit, how old were you when you quit?__________ Years old

*** 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 past ☐ Never

FINANCIAL INFORMATION: Do you receive ...

Medicaid ☐ Yes ☐ No Date applied ________________   SSD Disability ☐ Yes ☐ No Date applied ________________

Medicare ☐ Yes ☐ No Date applied ________________   Other Disability ☐ Yes ☐ No Date applied ________________

SSI Disability ☐ Yes ☐ No Date applied ________________

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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 being treated for this pain?
   ☐ No ☐ Yes, by whom? ______________________
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 No Pain	1	2	3	4	5	6	7	8	9	10 Worst Pain Imaginable

5. At what pain level would you be comfortable?

0 No Pain	1	2	3	4	5	6	7	8	9	10 Worst Pain Imaginable

6. How much does your pain interfere With your daily activities?

0 Not At All	1	2	3	4	5	6	7	8	9	10 Completely

7. What makes the pain better? ______________________
8. What makes the pain worse? ______________________
9. Are you taking medication for pain? ☐ No ☐ Yes
10. If yes, list all medications you are taking for pain. Include prescription medications, over the counter medications, and herbal remedies.
    ____
11. Are you using other treatment for pain? (heat, cold, physical therapy, acupuncture, hypnosis) ☐ No ☐ Yes
12. If yes, list all of these treatments ______________________

Patient, please *DO NOT write in this space.*

PAIN ASSESSMENT

Description ______________

Effectiveness of current pain treatment: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Side effects of current pain treatment Check all relevant: ☐ Constipation ☐ Dry Mouth ☐ Nausea ☐ Drowsiness ☐ Other ______

Additional Comments/Interventions ______________

____

PLAN: (see IPOC) Patient/Family Teaching: (see IPTR)

EDUCATIONAL NEEDS ASSESSMENT & TEACHING

LEARNING NEED ☐ No ☐ Yes (See Interdisciplinary Patient Teaching Record)

Patient Preferred Learning Preferences *(Check all that apply)*

☐ Visualization (seeing/reading information) ☐ Doing (touching and practicing skill) ☐ Hearing (auditory)

Supplementary Documentation

Utilize this are to document management of alterations.

Document by: D - Data, A - Action, R - Response, T - Teaching, (see Interdisciplinary Patient Teaching Record)

DATE	

PATIENT/SIGNIFICANT OTHER SIGNATURE	DATE/TIME	SIGNATURE/TITLE OF HEALTHCARE WORKER	CENTER	DATE/TIME