**The C.R. Wood Cancer Center**

**At**

**Glens Falls Hospital**

**Specializing in both Oncology and Hematology**

Please complete the questions on the following pages as best as you can and bring this form to your appointment.

This information will help us to understand who you are and what we can do to assist you during this experience.

You will review this form with a Nurse who will be able to answer any questions or concerns that you have and assist you with any areas that may be difficult to answer.

There is a team of professionals available to you and we are interested in helping both you and those people who are important to your life. Please do not hesitate to ask questions and take advantage of the services available through the Cancer Center.

Thank you,

The Staff of the C.R. Wood Cancer Center

**Please check in at the Cancer Center Reception Desk on the 1st floor in the Pruyn Pavilion.**

**For questions please call 518-926-6620**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_**

**Your Care Team:**

Family Physician/PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gynecologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Do you have any Allergies? 🞎 yes 🞎 no**

**ALLERGIES What type of reaction do you have?**

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

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**Do you take any prescription or over the counter medication? 🞎 Yes 🞎 No**

If yes, please list: **Please include herbs & vitamin supplements**

### **DRUG NAME DOSE FREQUENCY REASON**

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

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**List your past health history with dates (illness/problems, surgeries, injuries):**

**Illness or Problem/Date: Surgery/Date: Injury/Date:**

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

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If applicable, please list date of last: **Colonoscopy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PAP Smear**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Following is a list of questions regarding your family members. It is important for us to get as much information as possible, especially concerning any cancer or blood related problems in your family. List all family members, regardless of whether they have any health concerns. Please include any information that is known to you. For information that you are not sure of, it may be helpful to ask other family members. Please write unknown if you do not know the answer to a question. Remember, what may not seem important to you could be very important to us. (Examples of other conditions: high blood pressure, heart problems, breathing difficulties, seizures, mental retardation, stroke, eye problems, etc.)

| Relative | Cancer or blood related problem  (Answer Yes or No;  what type? list all if more than one problem) | Age at  Diagnosis | Other Illnesses or  Medical Conditions\*\*  (Yes/No: what type of condition?) | Death  (Yes/No)  Cause & Age |
| --- | --- | --- | --- | --- |
| Parents:  Father  Mother | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sisters:  (names and ages)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Brothers:  (names and ages)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sons/Daughters:  (names and ages)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Grandparents, aunts, uncles, first cousins)  (names and ages)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Social History:**

Do you currently smoke? 🞎 Yes 🞎 No If yes, how long have you smoked? \_\_\_\_\_ # years

Have you ever smoked? 🞎 Yes 🞎 no  If yes, when did you stop? \_\_\_\_\_ # years ago

What do/did you smoke and how much per day?

cigarettes: 🞎 yes 🞎 no \_\_\_\_\_\_\_\_ per day  currently

cigars: 🞎 yes 🞎 no \_\_\_\_\_\_\_\_ per day  currently

pipe: 🞎 yes 🞎 no \_\_\_\_\_\_\_\_ per day  currently

chew: 🞎 yes 🞎 no \_\_\_\_\_\_\_\_ per day  currently

Do you drink alcohol (wine, beer or liquor)? 🞎 Yes 🞎 No

If yes, how often do you drink and how much do you drink?

daily \_\_\_\_\_drinks weekly \_\_\_\_\_drinks occasional

Do you use recreational drugs? 🞎 Yes 🞎 No If yes, list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of drug or alcohol abuse? 🞎 Yes 🞎 No

**Home/Environment:**

Are you: 🞎 married 🞎 single 🞎 divorced 🞎 widow(er)

Do you live: 🞎 alone 🞎 with spouse 🞎 with family 🞎other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any type of homecare services that you use: 🞎 yes 🞎 no

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any type of homecare equipment that you use: 🞎 yes 🞎 no

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need assistance with Activities of Daily Living 🞎 yes 🞎 no

**Psychosocial:**

Are there religious, spiritual, or cultural beliefs that are important to you? 🞎 yes 🞎 no

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you have a lot of stress in your life? 🞎 yes 🞎 no

If yes, what things are causing stress for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you working: 🞎 yes 🞎 no 🞎 retired

If **yes**: 🞎 full time 🞎 part time Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If **no**, do you plan to return to work? 🞎 yes 🞎 no 🞎 unsure at present

Have you been exposed to hazardous materials? 🞎 yes 🞎 no

If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise on a regular basis? 🞎 yes 🞎 no

If yes, how often? 🞎 1-2 times/week 🞎 3-4 times/week 🞎 5-6 times/week 🞎 Daily

Activity 🞎 Walking 🞎 Aerobics 🞎 Running 🞎 Swimming 🞎 Weight lifting 🞎 Yoga

🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check if you have noticed a change in your energy level when:

🞎 eating 🞎 walking 🞎 bathing 🞎 doing housework

🞎 shopping 🞎 dressing 🞎 cooking 🞎 doing hobbies

Are any of these new? 🞎 yes 🞎 no If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check if you are experiencing any problem with sleep:

🞎 difficulty falling asleep 🞎 do not feel rested after sleeping

🞎 difficulty staying awake 🞎 usually feel rested after sleeping

🞎 Other sleep related problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe / write a list of what helps you sleep: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sexuality/Reproductive:**

Are you sexually active? 🞎 yes 🞎 no

Are you and your partner currently any using birth control? 🞎 yes 🞎 no

If yes, what method? 🞎 pills 🞎 IUD 🞎 condoms 🞎 diaphragm 🞎 patch 🞎 rhythm

🞎 Tubal ligation 🞎 vasectomy 🞎 other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns about fertility preservation? 🞎 yes 🞎 no

Often people diagnosed with cancer have some concerns regarding sexual activity or sexuality; do you have any such concerns? 🞎 No 🞎 Yes (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Female Specific**:

Do you now or have you ever taken any Hormones such as estrogen, birth control pills or injections? 🞎 yes 🞎 no If yes, what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of years used: \_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following breast symptoms? If yes, please check:

🞎 Fibrocystic Disease 🞎 Tenderness 🞎 Nipple Discharge 🞎 Masses 🞎 Other: \_\_\_\_\_\_\_\_\_\_

Do you know how to perform a self-breast exam? 🞎 yes 🞎 no

Do you perform breast self-exams? 🞎 yes 🞎 no

Would you like to learn how to perform a self-breast exam? 🞎 yes 🞎 no

Do you have any unusual vaginal discharge? 🞎 yes 🞎 no

Do you have any concerns about changes in your body? 🞎 yes 🞎 no

Number of Pregnancies \_\_\_\_\_ Number of Live Births \_\_\_\_\_ Age of first live birth: \_\_\_\_\_\_

**Menstrual History**:

Menstrual Status: 🞎 Menopausal 🞎 Post- Menopausal Last Menstrual Period: \_\_\_\_\_\_\_

Age of First Period: \_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_ Length: \_\_\_\_\_\_\_\_\_\_

Age of Last Period: \_\_\_\_\_\_\_\_\_

Description of Menstruation: 🞎 Amenorrhea 🞎 Dysmenorrhea 🞎 Irregular 🞎 Menopausal

🞎 Missed periods 🞎 Normal 🞎 Post-menopausal 🞎 Prior Abnormal 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_

**Male Specific**:

Have you had a vasectomy? 🞎 yes 🞎 no If yes, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have the any of the following symptoms? If yes, please check:

🞎 History of infection 🞎 Penile Discharge 🞎 Penile Lesions

🞎 Testicular Pain 🞎 Testicular Swelling 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you perform self-testicular exams? 🞎 yes 🞎 no

Would you like to learn how to perform a self-testicular exam? 🞎 yes 🞎 no

**Transfusion History:**

Have you ever received a blood or blood product transfusion: 🞎 Yes 🞎 No

If yes, did you have an adverse reaction? 🞎 Yes 🞎 No

If yes, check type of reaction: 🞎 Bloody Urine 🞎 Chills 🞎 Fainting/Dizziness 🞎 Fever

🞎 Flank Pain 🞎 Hives 🞎 Rash 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is a blood product transfusion acceptable to you if needed? 🞎 Yes 🞎 No

Are there any restrictions? 🞎 Yes 🞎 No If yes, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of bleeding problems: 🞎 Yes 🞎 No

If yes, list details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hematology History: \*\***Complete only if you have had problems with blood clotting in the past\*\*

Do you have a history of clotting problems: 🞎 Yes 🞎 No

If yes, list details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you think you have a tendency to develop abnormal blood clots: 🞎 Yes 🞎 No

If yes, when did this begin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the circumstances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you had any of the following prior to developing a clot: 🞎 Surgery/Procedure 🞎 Trauma

🞎 Hospitalized 🞎 Pregnancy 🞎 Oral Contraceptive Use 🞎 Estrogen Replacement Use

🞎 Cancer 🞎 Air Travel 🞎 Car trip over 4 hours 🞎 Bed rest longer than 4 days

Long Term effects of blood clots:🞎 Leg pain at rest 🞎 Leg pain w/walking 🞎 Leg cramps at rest

🞎 Leg cramps w/walking 🞎 Leg swelling 🞎 Leg swelling that varies by time of day

🞎 Discoloration of legs 🞎 Leg ulcers 🞎 Limitations in: recreational activities, work or self-care

**Check if you are experiencing any of the following:**

Respiratory: 🞎 Shortness of Breath 🞎 Cough

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiovascular: 🞎 Chest Pain 🞎 Palpitations 🞎 Dizziness 🞎 Swelling

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gastrointestinal: 🞎 Abdominal Pain 🞎 Nausea 🞎 Vomiting 🞎 Constipation 🞎 Diarrhea

🞎 Bloating 🞎 Blood in Stool 🞎 Hemorrhoids 🞎 Up at night to go

Date of your last Bowel Movement: \_\_\_\_\_\_\_\_\_\_\_

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genitourinary: 🞎 Dribbling 🞎 Burning 🞎 Pain 🞎 Trouble starting to go 🞎 Frequency

🞎 Blood in urine 🞎 No control 🞎 Up at night to go (# of times \_\_\_\_\_\_ )

Skin: 🞎 Bruising 🞎 Change in skin color 🞎 Itching 🞎 Rash 🞎 Lesion

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurological: 🞎 Hearing 🞎 Seizures 🞎 Smell 🞎 Speech 🞎 Confusion/Disorientation

🞎 Dizziness 🞎 Drowsiness 🞎 Faintness 🞎 Headache 🞎 Numbness 🞎 Tingling

🞎 Visual changes 🞎 Weakness 🞎 Other

Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neuromuscular: 🞎 Joint Stiffness 🞎 Joint Swelling 🞎 Numbness 🞎 Tingling 🞎 Weakness

🞎 Other Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a **Central Venous Access Line**: 🞎 Yes 🞎 No

If yes, list type, location and insertion date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated with radiation therapy? 🞎 Yes 🞎 No If yes, please describe: \_\_\_\_\_\_

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

Are you currently using any methods of cancer treatment? 🞎 Yes 🞎 No If yes, what methods?

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

Do you have a prescription plan? 🞎 Yes 🞎 No If yes, who is your plan with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Health:** Who is your dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was your last dental exam? \_\_\_\_\_\_

Do you have any loose teeth? 🞎 Yes 🞎 No

Do you have dentures? 🞎 Yes 🞎 No If yes: 🞎 Upper 🞎 Lower 🞎 Partial

Are you having any dental problems? 🞎 Yes 🞎 No If yes, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diet and Nutrition:**

Have you had any weight change in the last 3 months? 🞎 Yes 🞎 No

If yes, number of pounds \_\_\_\_\_\_\_\_\_\_\_ 🞎 lost 🞎 gained

Check the word(s) that describe your diet:

¨ regular ¨ liquid ¨soft ¨diabetic ¨ pureed ¨ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check if you are experiencing any of the following: 🞎 Loss of appetite 🞎 Nausea 🞎 Vomiting

🞎 Metallic taste 🞎 Indigestion 🞎 Mouth sores 🞎 Difficulty swallowing 🞎 Difficulty chewing

🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are any of these new? 🞎 Yes 🞎 No

If yes, which ones? 🞎 Loss of appetite 🞎 Nausea 🞎 Vomiting 🞎 Metallic taste 🞎 Indigestion

🞎 Mouth sores 🞎 Difficulty swallowing 🞎 Difficulty chewing 🞎 Other

**Sensory:**

Do you wear: 🞎 Glasses 🞎 Contacts 🞎 Hearing Aid(s)

Do you have a history of: 🞎 Cataracts 🞎 Glaucoma 🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your eye doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last eye exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychosocial:**

Do you feel like you have a lot of stress in your life? 🞎 Yes 🞎 No

In the last year, have there been any major events in your life besides your illness? 🞎 Yes 🞎 No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently seeing a counselor or psychologist? 🞎 Yes 🞎 No

If yes, who are you working with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in talking with a counselor for support or help coping with your illness?

🞎 Yes 🞎 No

Is anyone in your family interested in speaking with a counselor? 🞎 Yes 🞎 No

Have you had experience with cancer in the past? 🞎 Yes 🞎 No

What concerns you most about your health problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have an Advanced Directive?** 🞎 Yes 🞎 No Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, what type: 🞎 Durable Power of Attorney 🞎 Health Care Proxy 🞎 Living Will

🞎 Extended Care Facility DNR 🞎 Nonhospital DNR 🞎 MOLST 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the name of Power of Attorney or Health Care Proxy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\* Please bring a copy with you if it is not already on file at Glens Falls Hospital\*\***

If you do not have an Advanced Directive, would you like information about it? 🞎 Yes 🞎 No

**Fall Risk:**

Have you fallen 2 or more times in the last 12 months? 🞎 Yes 🞎 No

If yes, were you injured? 🞎 Yes 🞎 No Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nurse Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_