Hunterdon Healthcare
Your full circle of care.
Hunterdon Regional Cancer Center
Hunterdon Medical Center
2100 Wescott Drive, Flemington, NJ 08822, Phone: 1-888-788-1260
www.hunterdonregionalcancercenter.org

NCI Community Oncology Research Program
A program of the National Cancer Institute of the National Institutes of Health

PATIENT QUESTIONNAIRE

Please bring completed to appointment with photo ID and insurance card(s)

Name: _____ Date of Birth: _____ Today's Date:_____

Height:_____ Weight:_____

Reason for visit:_____
_____
_____

Biopsy Date: _____ Facility (HMC, etc): _____
Surgery Date: _____ Facility: _____

Family Physician: _____ Medical Oncologist: _____
Surgeon: _____ Plastic Surgeon: _____

List any other physicians involved in your overall medical or cancer care (GI, Pulmonologist, etc): _____

Recent Imaging Studies (Please list approximate dates and facility):

☐ Mammogram	Date:_____ Facility:_____	☐ PET/CT	Date:_____ Facility:_____
☐ CT Scan	Date:_____ Facility:_____	☐ MRI	Date:_____ Facility:_____
☐ Other _____	Date:_____ Facility:_____	☐ Ultrasound	Date:_____ Facility:_____

Have you had:

A. Chemotherapy? No☐ Yes☐ If yes, last infusion Date: _____
Facility:_____ Physician:_____
Name of Chemotherapy_____

B. Hormone therapy? No☐ Yes☐ If yes, when did it start: _____
Facility:_____ Physician:_____

C. Radiation therapy? No☐ Yes☐ If yes, approx dates of treatment: _____
Area of body treated: _____
Facility:_____ Physician:_____

Name: _____

Please list:

Medical Conditions:	**Past Surgeries and Dates:**	
1.	1.	Date:
2.	2.	Date:
3.	3.	Date:
4.	4.	Date:
5.	5.	Date:

Family History (Blood Relatives):

A. Any family members with cancer history? No ☐ Yes ☐ If yes, please list relation and type of cancer:_____
_____
B. Father: ☐ Alive, Age____ or ☐ Deceased, Age___ cause_____
C. Mother: ☐ Alive, Age____ or ☐ Deceased, Age___ cause_____

Social History:

A. Occupation_____ Currently employed? No☐ Yes☐
B. Marital status: ☐ Married, ☐ Single, ☐ Widow/Widowed, ☐ Divorced, ☐ Significant Other
C. Children: No☐ Yes☐ If yes, how many and ages: _____
_____
D. Who do you live with?_____
E. Hobbies/interests_____
F. Do you drink alcohol? No☐ Yes☐ how many drinks per week?____Type of alcohol_____ Do you drink caffeine? No☐ Yes☐
G. ☐ Never Smoked
☐ Active Smoker, How many packs of cigarettes per day? _____# of years_____
☐ Former Smoker, How many packs of cigarettes per day? _____
Quit how many years ago? _____
H. Any history of drug abuse/addiction? No☐ Yes☐ Type of drug_____
I. Autoimmune diseases? No☐ Yes☐ If yes, what type? _____
J. Inflammatory bowel disorders? No☐ Yes☐ If yes, what type? _____
K. Radon, asbestos, or other exposures? No☐ Yes☐ If yes, what type? _____
L. Assistive device/mobility: Cane☐ Walker☐ Wheelchair☐
M. Do you have transportation? No☐ Yes☐

Do you have a living will? No☐Yes☐Do you have a durable power of attorney? No☐ Yes☐

If yes, please bring in a copy of your living will and power of attorney.

Name: _____

Do you CURRENTLY have any of the following conditions or symptoms (Check all that apply):

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain >10 lbs
- ☐ Weight Loss >10 lbs
- ☐ Chills
- ☐ Night Sweats
- ☐ Trouble Sleeping

SKIN
- ☐ History skin cancer
- ☐ Open wounds
- ☐ Nail changes
- ☐ New lesions
- ☐ Rash
- ☐ Skin color changes

HEENT
- ☐ Double vision
- ☐ Eye pain
- ☐ Decreased vision
- ☐ Decreased hearing
- ☐ Earache/ear ringing
- ☐ Nose bleeds
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Oral ulcers
- ☐ Sore throat
- ☐ Pain when swallowing

Date of last dental exam:_____

HEMATOLOGY
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Prolonged bleeding

PAIN

Do you have pain?
No___ Yes☐
Location:_____
Describe:_____

RESPIRATORY
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Decreased exercise tolerance
- ☐ Difficulty breathing
- ☐ Coughing up blood
- ☐ Sputum production
- ☐ Wheezing

BREAST
- ☐ Breast mass
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Nipple inversion

Date of last mammogram:
_____

CARDIOVASCULAR
- ☐ Heart disease
- ☐ Chest pain
- ☐ Leg pains with walking
- ☐ Leg swelling
- ☐ Night awakening due to trouble breathing
- ☐ Palpitations
- ☐

Pacemaker/defibrillator☐

ENDOCRINE
- ☐ Appetite changes
- ☐ Cold intolerance
- ☐ Increased thirst
- ☐ Hair changes

Pain scale:
0 1 2 3 4 5 6 7 8 9 10

GENITOURINARY

Are you sexually active?
☐Y ☐N
- ☐ Difficulty starting/ stopping urinary stream
- ☐ Painful urination
- ☐ Change in urinary stream
- ☐ Increased frequency
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Nighttime urination
- ☐ Urinary retention

FEMALES ONLY
- ☐ Vaginal discharge
- ☐ Menstrual irregularities

Age of first period_____
Age of first pregnancy_____
Are you pregnant? ☐Y ☐N
Number of pregnancies_____
Did you breast feed? ☐Y ☐N
Did you ever take birth control? ☐Y ☐N
Did you ever take hormone/fertility treatment?
☐Y ☐N
Date of last GYN exam:
_____
Date of last pap smear:
_____
Date of last menstruation:
_____
Date of menopause:
_____

Breast Cancer Patients
Bra size:_____

MALES ONLY
- ☐ Impotence
- ☐ Testicular pain
- ☐ Enlarged prostate
- ☐ Previous biopsy

MUSCULOSKELETAL
- ☐ Decreased range of motion
- ☐ Joint swelling
- ☐ Muscle aches/pains
- ☐ Back pain
- ☐ Bone pain
- ☐ Balance difficulty
- ☐ Fallen recently
- ☐ Weakness
- ☐ Arthritis

NEUROLOGICAL
- ☐ Loss of bowel control
- ☐ Dizziness/vertigo
- ☐ Headaches
- ☐ Numbness/tingling
- ☐ Passing out
- ☐ Seizures
- ☐ Tremor
- ☐ Memory problems

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Gastric reflux
- ☐ Rectal bleeding
- ☐ Trouble swallowing

Date of last colonoscopy:
_____

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal thoughts

Reviewed by: _____ Physician Signature: _____ Date: _____

Patient Medication List

Patient Name:	Date of Birth:
Primary Pharmacy:	Pharmacy Phone Number:

PLEASE LIST ALL OF YOUR ALLERGIES	TYPE OF REACTION

Please list all of your medications:
Prescription, over-the-counter medications, vitamins, **and** herbal supplements

NAME OF MEDICATION	DOSE	FREQUENCY

Patient Self-Assessment Form

Date: _____ DOB:_____

Full name: _____

Which best describes your preference for learning?
☐ Verbal ☐ Demonstration ☐ Printed Materials ☐ Internet-based ☐ Video

Pain & Discomfort Information

1. Have you experienced pain within the last week?
   ☐ Yes *(If yes, please answer questions 2-8)*
   ☐ No

2. Where is your pain located? _____

3. Please rate your pain on a scale of 0 – 10 _____

0	1	2	3	4	5	6	7	8	9	10
None/Mild					Moderate Pain					Severe Pain

4. Is your pain level acceptable? ☐ Yes ☐ No

5. How often do you have pain? _____

6. Do you take pain medication? If yes, please list medication and dosage:

   _____

7. If you take pain medication, does it relieve your pain to your satisfaction? ☐ Yes ☐ No

8. Other than taking medication, do you do anything else to relieve your pain? _____

_____

_____

9. Would you like assistance in managing your pain? ☐ Yes ☐ No

Psychosocial Information

1. Do you live alone? ☐ Yes ☐ No If not, with whom do you live?

_____

2. Do you feel safe in your home? ☐ Yes ☐ No
3. Do you drive? ☐ Yes ☐ No If not, who does? (Name / relationship):

_____

4. Your occupation:

_____

___

Employment status: ☐ Currently employed ☐ Retired ☐ Unemployed ☐ Disability

5. Are you, or someone in your household, a current college student? ☐ Yes ☐ No
6. Do you have financial concerns relating to your care? ☐ Yes ☐ No

If yes, please indicate from the following options:

☐Insurance co-pay ☐ Insurance deductibles ☐ Groceries ☐Gas (car)
☐ Housing

☐ Medications ☐ Medical supplies ☐ Utilities

7. Please rate your level of distress over the past two weeks: _____

0	1	2	3	4	5	6	7	8	9	10
Mild					Moderate					High

8. Over the last two weeks have you experienced:

Little interested in activities you usually enjoy? ☐ Most days ☐ Some days ☐ Never

Feelings of hopelessness? ☐ Most days ☐ Some days ☐ Never

Uncontrollable worry? ☐ Most days ☐ Some days ☐ Never

Inability to care for yourself and/or complete household chores due to physical health?
☐ Most days ☐ Some days ☐ Never

9. If you are a caregiver, who requires your care (parent, child, spouse, etc.)?

_____

10. Is there someone who can help you with daily tasks if needed? ☐ Yes ☐ No If yes, who?

_____

11. Are you able to talk to your family or friends about your illness? ☐ Yes ☐ No

12. Are you interested in support groups or educational programs? ☐ Yes ☐ No

13. Are you a Veteran? ☐ Yes ☐ No If yes, are you receiving Veteran's benefits? ☐ Yes ☐ No

14. Do you have religious / cultural / spiritual beliefs that we should be aware of to better care for you?

_____

_____

15. Are you interested in learning more about integrative medicine, such as acupuncture, meditation, therapeutic massage, or Reiki therapy? ☐ Yes ☐ No

16. Do you have a current advanced directive? ☐ Yes ☐No Are you interested in completing/updating one? ☐Yes ☐No

17. Are you having difficulty making treatment decisions? ☐ Yes ☐ No

18. Have you wished you were dead or wished you could go to sleep and not wake up? ☐ Yes ☐ No

19. Have you had any actual thoughts of killing yourself? ☐ Yes ☐ No

20. Have you ever done anything, started to do anything or prepared to do anything to end your life? ☐ Yes ☐ No

If yes was this within the past 3 months? ☐ Yes ☐ No

Nutrition Information

1. Weight

In summary of my current and recent weight:
I currently weigh about _____ pounds.
I am about _____ feet _____ inches tall.
One month ago, I weighed about _____ pounds.
Six months ago, I weighed about _____ pounds.
During the ***past two weeks***, my weight has:

- ☐ Decreased (1)
- ☐ Not changed (0)
- ☐ Increased (0)

Box 1: _____

2. Food Intake

As compared to my normal intake, I would rate my food intake during the ***past month*** as:

- ☐ Unchanged (0)
- ☐ More than usual (0)
- ☐ Less than usual (1)

I am now taking:

- ☐ *Normal food*, but less than normal amount (1)
- ☐ Little solid food (2)
- ☐ Only liquids (3)
- ☐ Only nutritional supplements (3)
- ☐ Very little of anything (4)
- ☐ Only tube feedings or only nutrition by vein (0)

Box 2: _____

3. Symptoms

I have had the following problems that have *kept me from eating enough during the **past two weeks*** (check all that apply):

- ☐ No problems eating (0)
- ☐ Vomiting (3)
- ☐ Diarrhea (3)
- ☐ Dry mouth (1)
- ☐ Smells bother me (1)
- ☐ Feel full quickly (1)
- ☐ Fatigue (1)
- ☐ No appetite, just did not feel like eating (3)
- ☐ Nausea (1)
- ☐ Constipation (1)
- ☐ Mouth sores (2)
- ☐ Things taste funny or have no taste (1)
- ☐ Problems swallowing (2)
- ☐ Pain; where: _____ (3)
- ☐ Other**: _____

**Examples: depression, money, or dental problems

Box 3: _____

4. Activities and Function:

Over the ***past month***, I would generally rate my activity as:

- ☐ Normal with no limitations (0)
- ☐ Not my normal self, but able to be up and about with fairly normal activities (1)
- ☐ Not feeling up to most things, but in bed or chair less than half the day (2)
- ☐ Able to do little activity and spend most of the day in bed or chair (3)
- ☐ Pretty much bedridden, rarely out of bed (3)

Box 4: _____

Additive score of Boxes 1-4: _____

****Dietitian will tally score****

Nursing Only

Checklist:

Medical advanced directive: ☐Yes ☐No

Information given: ☐Yes ☐No ☐N/A

Filed on chart: ☐Yes ☐No ☐N/A

Does HMC already have a copy? ☐Yes ☐No

Copy sent to medical records? ☐Yes ☐No

Mental health advanced directive: ☐Yes ☐No

Reviewed by: _____

Date: _____

Patient presented to new patient team? ☐Yes ☐No

Date: _____

By: _____

Referrals:

To Psychosocial: ☐Yes ☐No
Reason: _____
Date: _____

To Clinical Dietitian: ☐Yes ☐No
Reason: _____
Date: _____

To Palliative Care: ☐Yes ☐No
Reason: _____
Date: _____

To Center for Healthy Aging: ☐Yes ☐No
Reason: _____
Date: _____

To Risk Assessment: ☐Yes ☐No
Reason: _____
Date: _____

To Research: ☐Yes ☐No
Reason: _____
Date: _____

To Speech Therapy: ☐Yes ☐No
Reason: _____
Date: _____

To Oncology Rehab: ☐Yes ☐No
Reason: _____
Date: _____

To PCP: ☐Yes ☐No
Reason: _____
Date: _____