NWH NORTHERN WESTCHESTER HOSPITAL
Expertise • Technology • Humanity

Demographics

CANCER TREATMENT AND WELLNESS CENTER
HISTORY SUMMARY SHEET

Today's Date: _____

MEDICATIONS: _____ _____
Include Prescriptions, _____ _____
Over the counter, and _____ _____
Herbal Medications

ALLERGIES: _____ _____

PREVIOUS OPERATIONS: Please list year & hospital:
Eye Surgery _____
Tonsillectomy _____
Thyroid Surgery _____
Lung Surgery _____
Heart Surgery _____
Gallbladder Surgery _____
Hysterectomy _____
D&C _____
Appendectomy _____
Hernia Surgery _____
Bladder Surgery _____
Prostate Surgery _____
Spinal Surgery _____
Other _____

HAVE YOU BROKEN ANY BONES? If yes, please list:
Which Bone? _____ Date: _____
Which Bone? _____ Date: _____
Which Bone? _____ Date: _____

HAVE YOU EVER HAD RADIATION THERAPY? Yes _____ No _____
When? _____ Where? _____
Radiation Oncologist's Name: _____
What part(s) of the body were treated? _____
How many treatments? _____

HAVE YOU HAD HORMONE THERAPY OR CHEMOTHERAPY? Yes ___ No ___
Medication: _____ Date: _____
Medication: _____ Date: _____
Medication: _____ Date: _____

HAVE YOU HAD ANY OF THE FOLLOWING? If yes, please check:

_____ History of Cancer
_____ Fever
_____ Fatigue
_____ Weight Loss
_____ Pain, where? _____
_____ Headaches
_____ Vision Problems
_____ Hearing Problems
_____ Sinus Problems
_____ Thyroid Disease
_____ Sore Throat
_____ Hoarseness
_____ Cough
_____ Blood in Sputum
_____ Emphysema
_____ Chronic Bronchitis
_____ Asthma
_____ Positive TB Test
_____ Heart Attack
_____ High Blood Pressure
_____ Shortness of Breath
_____ Chest Pain
_____ Pacemaker
_____ Reflux
_____ Nausea
_____ Vomiting
_____ Decreased Appetite
_____ Diarrhea
_____ Constipation
_____ Blood in Stool
_____ Hemorrhoids
_____ Laxative Use
_____ Hernias
_____ Abdominal Pain
_____ Frequent Urination
_____ Slow Urination
_____ Pain or Burning
_____ Blood in Urine
_____ Kidney Stones
_____ Incontinence
_____ Erectile Dysfunction
_____ Leg Swelling
_____ History of Blood Clots
_____ Neurological Disorders
_____ Weakness in Limbs
_____ Paralysis
_____ Stroke
_____ Seizures
_____ Arthritis
_____ Gout
_____ Diabetes
_____ Anemia
_____ Other _____

FEMALES: Please complete the following information:
Could you be pregnant now? Yes _____ No _____
Age of First Period: _____
Number of Pregnancies: _____ Number of Deliveries: _____
Did you breastfeed? Yes_____ No _____
Are you still having periods? Yes _____ No _____ Date of Last Period: _____
Did you ever take birth control pills? Yes _____ No _____
Did you ever take hormone replacement? Yes _____ No _____

FAMILY HISTORY:

Parents:
Father: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____
Mother: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____

Siblings:
Brother/Sister: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____
Brother/Sister: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____
Brother/Sister: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____
Brother/Sister: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____
Brother/Sister: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____

Children:
Son/ Daughter: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____
Son/ Daughter: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____
Son/ Daughter: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____
Son/ Daughter: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____
Son/ Daughter: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____

Grandchildren: Yes: _____ No _____ Any medical problems? _____

Is there any other family history of cancer? Please describe: _____
_____
_____
_____
_____

SOCIAL HISTORY:
Where were you born? _____
Where have you lived most of your life? _____

Have you ever smoked? Cigarettes _____ Pipe _____Cigar _____
If yes, how much per day? _____
For how many years? _____
Have you quit? _____ If yes, when? _____

Do you drink alcohol? _____ If yes, how much? _____ How often? _____
Do you drink coffee/tea? _____ If yes, how much? _____ How often? _____

WORK/EDUCATION HISTORY:
What is your occupation? _____
Are you still working? _____
Have you been exposed to asbestos or any other occupational chemicals or fumes? _____
If yes please describe _____
What is your highest level of education? (Please check one)
Elementary _____ High School _____ College _____ Some college _____ Graduate School _____
Did you ever serve in the military? _____ For how long? _____

MARITAL STATUS:
Are you? (check one) _____ Single _____ Married _____ Divorced ____Widowed
Spouse's name _____
Address: _____
Phone Number: _____

PLEASE LIST THE NAMES AND LOCATIONS OF YOUR PHYSICIANS:

Name	Specialty	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DIETARY HISTORY:

Usual number of meals per day _____ Had this changed recently? _____
Do you follow a special diet? _____ If yes, please explain_____
Do you feel full after eating very little? Yes ____ No _____
What is your usual weight? _____ What is your current height and weight? _____
Your weight 6 months ago? _____ 1 year ago? _____
Any change in the past 6 weeks? _____ If yes, has it? Increased _____ or Decreased_____
What is your current level of intake? Any food _____ Some solid food _____ Liquids only _____
Is your ability to eat limited by any of the following (please check ALL that apply)

Nausea ____	Dry Mouth _____	Aversion to odors _____
Vomiting ____	Mouth Sores _____	Pain____ where? _____
No appetite _____	Taste Change _____	

Form completed by: _____ Date: _____
Signature

Form reviewed by: _____ Date: _____
Signature and Title