ORLANDO HEALTH®

Mailing Address: 1414 Kuhl Ave. • Orlando, FL 32806

LINE UP PATIENT I.D. LABEL HERE

GENERAL ONCOLOGY: HEALTH INVENTORY

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

Referring Physician: _____ Location/Phone #: _____

Primary Care Physician: _____ Location/Phone #: _____

HR: _____ BP: _____ RR: _____ Temperature: _____

Height: _____ Weight: _____ (kg)

Past Cancer History Have you ever been diagnosed with cancer before? No Yes

Type of Cancer	Where treated (Doctor/Hospital/City)	When (Dates)

Family History of Cancer

Are you adopted?	No	Yes	Has any member of your family (blood relative) been diagnosed with cancer?			No	Yes
Relative			Type of Cancer		Age when diagnosed	Alive	
						No	Yes
						No	Yes
						No	Yes
						No	Yes

Past Radiation History

Have you ever received other radiation therapy or radioactive iodine in the past? No Yes Date: _____

Past Chemotherapy History

Have you ever received chemotherapy for another condition in the past? No Yes Date: _____

Past Surgical History

Please list all surgeries:			Date:
Any implanted devices (pacemakers, pumps, etc.)	No	Yes	

Past Medical History

Please add any additional medical issues:	Date:

Gynecologic History

Age at first menses: _____ Are you possibly pregnant now? No Yes Are you using birth control? No Yes

Number of pregnancies: _____ Number of live births: _____ Number of miscarriages: _____ Number of abortions: _____

Your age at first live birth: _____ Last menstrual period: _____ Age at menopause: _____

Have you used hormone replacement therapy? No Yes How long: _____

Last gynecologic examination: _____ Last Pap smear: _____

Fertility Preservation

Are you planning to have children in the future?	No	Yes	Would you like more information about protecting your ability to have children in the future (fertility preservation procedures)?	No	Yes

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Allergies Do you have any allergies? No Yes

Drug Name / Allergen	Type of Reaction

Medications

Please list all medication you are currently taking (including prescriptions, over the counter, vitamins, herbal supplements, alternative medicines, etc.)

Prescription Medications and Doses	Other Medications, Vitamins, Supplements, etc.

Pharmacy Name: _____ Pharmacy Location/Phone #: _____

General Health Review

Constitutional/Nutrition	No	Yes
Lack of Appetite		
Weight Loss/Gain		
Fevers		
Chills		
Night Sweats		
Fatigue		
Mild Fatigue: Improves with rest		
Moderate Fatigue: Does not improve with rest		
Severe Fatigue: Does not improve with rest and limits taking care of self		
Eyes	**No**	**Yes**
Do you have any eye problems?		
Blurry vision		
Decreased vision		
Dry eye(s)		
Painful eye(s)		
Other:		
Ear/Nose/Mouth/Throat	**No**	**Yes**
Do you have ear/nose or throat problems?		
Decreased hearing		
Ringing in the ears		
Ear pain		
Nose bleeding		
Problems eating/chewing/swallowing		
Do you have dentures?		
Hoarseness/voice changes		
Facial weakness or numbness		
Other:		
Heart (Cardiovascular)	**No**	**Yes**
Do you have heart problems?		
Chest pain		
Pain on exertion		
Dizziness/fainting		
Irregular heart beat		
Hypertension/High Blood Pressure		

Gastrointestinal	No	Yes
Do you have stomach or bowel problems?		
Nausea		
Vomiting		
Vomiting blood		
Stomach cramping / pain		
Heartburn		
Constipation		
Diarrhea		
Blood in stool		
Loss of bowel control		
Jaundice or yellow skin / eyes		
Hemorrhoids / rectal pain		
Colonoscopy? Date:		
Other:		
Genitourinary	**No**	**Yes**
Do you have urinary problems?		
Urinary frequency		
Urinary urgency		
Burning on urination		
Blood in urine		
Loss of urinary control		
Are you sexually active?		
Other:		
Male	**No**	**Yes**
Difficulty with erection		
Difficulty with ejaculation		
Enlarged prostate		
Other:		
Female	**No**	**Yes**
Hot flashes		
Pelvic pain		
Vaginal bleeding		
Vaginal discharge		
Other:		

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Respiratory	No	Yes
Do you have breathing problems?		
Cough		
Bloody phlegm / bloody sputum		
Shortness of breath		
Difficulty breathing / pain when breathing		
Do you use oxygen?		
Other:		
Muscle or bone (Musculoskeletal)	**No**	**Yes**
Do you have any bone/muscle problems?		
Back/neck pain		
Joint pains		
Muscle aches/pains		
Leg weakness		
Changes in mobility?		
Changes in activities of daily living (Bathing, Eating, Self-care)		
Neurological	**No**	**Yes**
Do you have any neurological problems?		
Headaches		
Numbness or tingling		
Memory problems		
Dizziness / vertigo		
Seizures		
Speech problems		
Weakness in face, arm or leg (not general tiredness)?		
Other:		
Psychiatric	**No**	**Yes**
Do you have any psychiatric or emotional problems?		
Depression		
Anxiety		
Difficulty sleeping		
Other:		
Allergic / Immunologic	**No**	**Yes**
Do you have allergies or asthma?		
Seasonal allergies or hay fever		
Asthma		
Hives		
Dermatitis / skin reactions		
Other:		

Skin/Breast	No	Yes
Do you have any skin problems?		
Rash		
Itching		
Open sores		
Nail Changes		
Other:		
Do you have any breast problems?		
Breast lump		
Breast pain		
Breast skin color change		
Breast skin break/ulcers		
Nipple discharge		
Armpit lump		
Endocrine	**No**	**Yes**
Do you have any endocrine problems?		
Excessive thirst		
Frequent urination		
Mood swings		
Cold intolerance		
Heat intolerance		
Goiter		
Thinning hair, constipation, dry skin, tiredness (symptoms or low thyroid)		
Diabetic		
Hematologic/Lymphatic	**No**	**Yes**
Do you have blood or lymph problems?		
Red or purple skin discolorations		
Prolonged or excessive bleeding		
Use of Aspirin or blood thinners		
Prior blood transfusions		
Lymphedema / arm or leg swelling		
Swollen or painful lymph nodes		
Other:		

Reviewed By

Medical Assistant: _____ Date: _____ Time: _____

Nurse: _____ Date: _____ Time: _____

Physician/Midlevel: _____ Date: _____ Time: _____

INTERPRETER ONLY

(Please Print)

Name: _____ Agency: _____

Telephone: _____ Language: _____