Celilo CANCER CENTER AT MID-COLUMBIA MEDICAL CENTER

1800 East 19th Street
The Dalles, OR 97058
Radiation Oncology – 541-296-7204
Medical Oncology – 541-296-7585

Name _____Date of Birth _____MRN#_____

- When was the last time you saw a dentist? _____ Dentures? ☐ Yes ☐ No
- How many times per week did you exercise prior to diagnosis? _____
- How would you like to receive educational information? printed MyChart verbal other
- Do you now or have you ever smoked or used smokeless tobacco? ☐ Yes ☐ No

  How many years? _____ How many packs per day? _____

HEALTH HISTORY: *This section helps us understand your past medical treatment, prior procedures or surgeries, ongoing medical concerns, what prescription drugs, herbs, or supplements you take, and what symptoms you may be currently experiencing.*

Known or suspected allergies to medication, food or other material including latex.

Preferred Pharmacy

Name	Location

Medications you are currently taking, including herbal or dietary supplements.

Medication/Herbal/Dietary Supplement	Strength or dosage	How often do you take it?	When did you last take it?

(attach Epic Medication Reconciliation if available)

Name _____

Past surgical or invasive procedures

Procedure	Date Occurred

Past medical diagnoses or conditions:

Condition	Date of Onset

SCALE OF PAIN SEVERITY 0-10: (Circle One from this chart ***OR*** *one from the pain assessment below)*

This section helps us understand your current level of physical discomfort so that we can better manage your pain.

Rating	Severity	Explanation of Experience	Rating	Severity	Explanation of Experience
0	**No Pain**	Essentially pain free	**6**	**Distressing**	Pain preoccupies thinking, must give up many routine activities due to pain
1	**Minimal**	Pain is hardly noticeable	**7**	**Unmanageable**	Constant pain that interferes with almost all activities, often must take time off work, nothing seems to help
2	**Mild**	Feel a low level of pain, aware of pain only when paying attention to it	**8**	**Intense**	Severe pain makes it hard to concentrate on anything but the pain; conversation is difficult
3	**Uncomfortable**	Pain is troubling but can be ignored most of the time	**9**	**Severe**	Can concentrate on nothing but the pain ,can do almost nothing, can barely talk, feeling overwhelmed by pain
4	**Moderate**	Constantly aware of the pain but can continue most routine activity	**10**	**Immobilizing**	Pain is as bad as you have EVER felt, unable to move except to seek immediate help, bedridden by pain
5	**Distracting**	Pain is barely tolerable, some routine activity is limited by pain			

PAIN ASSESSMENT: (Circle One) (Circle One from this chart ***OR*** *one from the scale of pain severity above)*

0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Moderate Severe Worst Pain Imaginable

Name _____

FAMILY HEALTH HISTORY: *Is there any family history of cancer, blood disorders, cardiovascular disease, or other medical problems? If so, record below: (M) = Maternal (P) = Paternal*

Family Member	Living status	Medical Problems	Family Member	Living status	Medical Problems
Mother	☐ Living ☐ Deceased		Grandmother (P)	☐ Living ☐ Deceased	
Father	☐ Living ☐ Deceased		Grandfather (P)	☐ Living ☐ Deceased	
Children	☐ Living ☐ Deceased		Aunt(s)	☐ Living ☐ Deceased	
Brother(s)	☐ Living ☐ Deceased		Uncles(s)	☐ Living ☐ Deceased	
Sister(s)	☐ Living ☐ Deceased		Cousin(s)	☐ Living ☐ Deceased	
Grandmother (M)	☐ Living ☐ Deceased		Other:	☐ Living ☐ Deceased	
Grandfather (M)	☐ Living ☐ Deceased		Other:	☐ Living ☐ Deceased	

If cancer diagnosis, were genetic tests obtained: ☐ Yes ☐ No If so, what were the results? _____

SYSTEM REVIEW: Do you **have** or have you **recently had** any of the following illnesses or symptoms?
(Please check all that apply)

☐ **Prior Chemotherapy Treatments**
When:_____
Where:_____

☐ **Prior Radiation Treatments**
When:_____
Where:_____

☐ Recent fevers
☐ Unintended weight loss – how much? _____
☐ Night sweats
☐ Excessive fatigue
☐ Lightheadedness
☐ Recent changes in vision
☐ Cataracts: R ___ L ___
☐ Change in hearing or ringing in ears
☐ Hearing aids: R ___ L ___
☐ Mouth, throat or tongue pain
☐ Hoarseness
☐ Difficulty swallowing
☐ Neck masses/lumps/nodes
☐ High blood pressure
☐ Leg swelling or prior blood clots
☐ Chest pain or angina

☐ Dry cough
☐ Productive cough
☐ Shortness of breath
☐ Coughing up blood
☐ Pain with deep breath
☐ Other cancers_____
☐ Diabetes
☐ Thyroid problem/goiter
☐ Hepatitis
☐ HIV
☐ Lupus or Scleroderma
☐ Multiple Sclerosis
☐ Constipation
☐ Diarrhea
☐ Blood in stools
☐ Change in stool size
☐ Change in bowel habits
☐ Nausea or vomiting
☐ Heartburn or indigestion
☐ Urinary incontinence
☐ Frequent urination
☐ Urinary burning
☐ Blood in urine
☐ Kidney problems

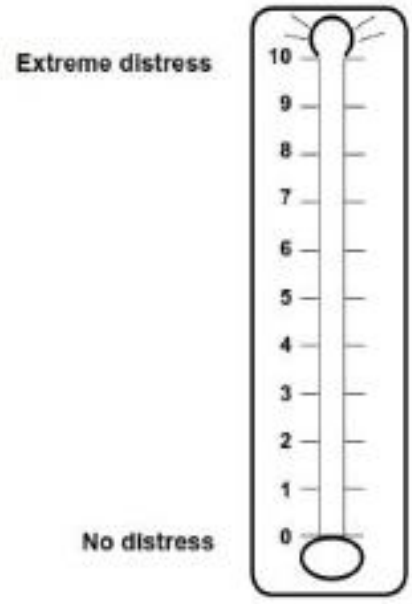
☐ Testicular lumps, pain, or swelling
☐ Prostate problems
☐ Impotence or erectile dysfunction
☐ Breast masses, breast pain, or nipple discharge
☐ Post-menopausal bleeding
☐ Painful intercourse
☐ Hot flashes
☐ Arthritis pain – where? _____
☐ Recent back pain
☐ Arm weakness
☐ Leg weakness
☐ Tremors or seizures
☐ Balance/coordination problems
☐ Recent headaches
☐ Confusion or memory loss
☐ Depression
☐ Anxiety
☐ Difficulty sleeping/insomnia
☐ Psychiatric problem _____
☐ Skin rashes
☐ Itching
☐ Other _____
_____

Name _____

ALCOHOL AND DRUG USE: When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.	
Have you ever felt that you ought to cut down on your drinking or drug use?	☐ Yes ☐ No
Have people annoyed you by criticizing your drinking or drug use?	☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking or drug use?	☐ Yes ☐ No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes ☐ No

NCCN DISTRESS TOOL

Instructions: Please circle the number (0-10) that best describes how much stress you have been experiencing in the past week including today.



PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week including today.
Be sure to check **YES** or **NO** for each.

YES	NO	Practical Problems
❑	❑	Childcare
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions
		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family Health Issues
		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	Spiritual Concerns

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance use
❑	❑	Tingling in hands/feet

Other Problems: _____
_____

_____ _____
Patient Signature **Date**

_____ _____
Physician Review **Date**