AFTER CANCER TREATMENT TRANSITION CLINIC INITIAL VISIT
Patient Assessment Form

Family Doctor Name: ________________________ **Telephone:** ______________________

Marital Status:	**Children**	**Employment Status:**	**Do you have a private drug plan?**
☐ Single ☐ Married/ Partner ☐ Divorced ☐ Widowed	☐ Yes How many? ___________________ ☐ No	Job/Occupation_____________ Are you currently working? ☐ Yes ☐ No	☐ Yes ☐ No

PAST MEDICAL HISTORY: DO YOU HAVE ANY OF THE FOLLOWING:		
☐ High Blood Pressure	☐ Diabetes	Other chronic health conditions (please list)
☐ Heart Disease/ Chest Pain	☐ Osteoporosis	☐
☐ Heart Attack	☐ Problems with kidney function	☐
☐ High Cholesterol	☐ Other cancer	☐

PAST SURGERIES: ***Do not include the surgeries related to the cancer you are being seen for***

DO YOU HAVE ANY ALLERGIES? **please list the type of reaction**: ☐ No Known Allergies

ARE YOU ALLERGIC TO CONTRAST or CT DYE? ☐ Yes ☐ No **REACTION**

Family History of Cancer:

Breast cancer ____________________________ Other cancers ___________________________________

Ovarian Cancer __________________________ Ashkenazi Jewish ☐ Yes ☐ No

BRCA 1/2 testing ☐ No ☐ Yes date ________________________ Institution ____________________________

PHYSICAL CONCERNS: In the **PAST 3 MONTHS** have you had any of these symptoms bother you? Please check all that are of concern.

Weight loss of 10lbs or more	Diarrhea Constipation	Persistent cough
Persistent fever/chills/sweats	Blood in stool	Coughing up blood
New Onset of Fatigue	Stool incontinence/lack of control	Shortness of breath
New Onset of Headaches	Urine incontinence/lack of control	Swollen lymph nodes/glands
Skin Changes	Persistent Nausea or Vomiting	Neck pain, swelling
OTHER:_____________	**OTHER** ___________________	**OTHER** ___________________

PLEASE LIST ALL THE MEDICATIONS YOU TAKE (PRESCRIPTION & NON PERSCRIPTION & VITAMINS) ATTACH LIST IF AVAILABLE.	
1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

HEALTH SCREENING: Have you had:				
Fecal Occult Blood Testing	No	Yes Year:_______	Normal	Abnormal
Colonoscopy	No	Yes Year:_______	Normal	Abnormal
Cholesterol, blood pressure	No	Yes Year:_______	Normal	Abnormal
Blood sugar check	No	Yes Year:_______	Normal	Abnormal
Bone Density Scan	No	Yes Year:_______	Normal	Abnormal
Pap smear (for Women)	No	Yes Year:_______	Normal	Abnormal
Mammogram	No	Yes Year:_______	Normal	Abnormal
Prostate Specific Antigen (PSA) (for Men)	No	Yes Year:_______	Normal	Abnormal

Do you smoke?

Never

Former smoker How long did you smoke? ______ years Packs per day______ When did you quit? _______

Currently smoking Packs per day_________ How long have you been smoking? __________ years

Do you drink alcohol?

No

Yes Drinks per day: ___________ **or** Drinks per week ____________ **or** Drinks per month ____________

Do you exercise?

No

Yes Type of Exercise: ________________________ ___________ minutes __________ times a week

Do you have any concerns to discuss today?

1 ____

2 ____

Contact information:

May we leave a message on your phone regarding:

1. Appointments: ☐ Yes ☐ No 2. Test results ☐ Yes ☐ No Phone number: _________________________

Person Completing Form:

Self Other Relationship ________________ Date (yyyy/mm/dd) _______________________