SWEDISH
CANCER INSTITUTE

SCI PATIENT INFORMATION

Today's Date:_____

Patient Name: _____ **Birthdate:** ____/____/____ **Age:**_____

Preferred Name: _____ **Marital status:** ☐ Single ☐ Married ☐ Separated ☐ Widow(er) ☐ Dependent ☐ Domestic Partner

Gender:_____ **Name of Partner/Spouse:**_____

Who referred you to this office?_____ **Reason for visit?**_____

Please list any other physicians currently treating you who should receive reports:

Dr._____ **Dr.**_____ **Dr.**_____

City:_____ **City:**_____ **City:**_____

Hospitalizations/Surgeries/Serious Illnesses/Injuries:	Date

Pharmacy:_____ **Location and Phone Number:** _____

Occupation or type of work that you do:_____

Do you have any work concerns? (i.e.: heavy lifting, stress, hazardous substances)_____

Activity: (check one or more boxes): ☐ Sedentary life with little exercise ☐ Mild exercise (climb stairs, walk over 3 blks, golf, bowl, etc.) ☐ Occasional vigorous activity ☐ Regular vigorous exercise program or hard work

Usual weight _____ **Present weight** _____ **Height:** _____

YOUR MEDICAL ISSUES: Check conditions you currently have or had been treated for in the past:

	Past	Current
AIDS		
Alcoholism		
Anemia		
Anesthesia problems		
Anxiety		
Arthritis		
Asthma		
Bleeding disorders		
Blood transfusion Dates:_____		
Breast lump		
Bronchitis		
Cancer:		
Chemical dependency		
Chicken pox		
Depression		
Diabetes		
Eating Disorders-Anorexia/Bulemia		

	Past	Current
Emphysema		
Glaucoma		
Goiter		
Gout		
Heartburn/reflux		
Heart disease		
Heart murmur		
Hepatitis		
Herpes		
High blood pressure		
High cholesterol		
HIV positive		
Infertility		
Kidney disease		
Liver disease		
Migraine headache		
Measles/mumps		
MRSA		

	Past	Current
Multiple sclerosis		
Pacemaker		
Pneumonia		
Polio		
Prostate problem		
Radiation Therapy Dates:_____		
Rheumatic fever		
Seizures		
Stroke		
Thyroid disease		
Tuberculosis		
Ulcers		
Vaginal infection		
Venereal disease		

Patient Name: _____ **Page 2**

Smoking ☐ Never	Alcohol	Caffeinated Beverages	Recreational Drugs
Packs/day_____ # of yrs_____ Year stopped_____ ☐ Pipe ☐ Cigar ☐ Chew	☐ Never ☐ Occasional Drinks/week_____ Alcohol problem: ☐ Past ☐ Present	Cups/cans per day_____ Aspirin: tablets per day _____	☐ No ☐ Yes If yes, list_____

SYSTEM REVIEW: Check if you have any of the following now or in the past l2 months

General
- ☐ Excessive hunger/thirst
- ☐ Fever
- ☐ Fainting
- ☐ Insomnia
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss
- ☐

Eyes, Ears, Nose. Throat
- ☐ Allergy/Hay fever
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Cataract
- ☐ Cough
- ☐ ↓ Vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Sinus trouble
- ☐

Cardiovascular
- ☐ Abnormal EKG
- ☐ Ankle swelling
- ☐ Chest pain/tightness
- ☐ Enlarged heart
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Palpitation
- ☐ Phlebitis
- ☐ Tire easily
- ☐ Varicose veins
- ☐

Respiratory
- ☐ Coughed up blood
- ☐ Persistent cough
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Wheezing / Asthma
- ☐

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Change in bowel habits
- ☐ Colitis/IBS/Crohn's
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Diverticulitis
- ☐ Gall stones
- ☐

Gastrointestinal, cont.
- ☐ Heart burn
- ☐ Hemorrhoids
- ☐ Indigestion/gas
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Passing blood
- ☐ Reflux
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Yellow jaundice
- ☐

Genitourinary
- ☐ Blood in urine
- ☐ Difficulty/painful urinating
- ☐ Incontinence/↓ bladder control
- ☐ Urine infection
- ☐ Urinary frequency
- ☐

Endocrine
- ☐ Hypoglycemia
- ☐ Hyperglycemic

Muscle/Joint/Bone
- ☐ Bursitis
- ☐ Muscle cramps
- ☐ Pain/weakness/numbness:
  - ☐ Arms, ☐ feet, ☐ hands, ☐ back,
  - ☐ neck, ☐ legs, ☐ shoulder
- ☐ Arthritis

Skin
- ☐ Bruise easily
- ☐ Changes in moles
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rash/hives
- ☐ Sore does not heal
- ☐

Neurological
- ☐ Balance problems
- ☐ Dizziness
- ☐ Falls
- ☐ Headache / Migraines
- ☐ Memory loss
- ☐ Parkinson's
- ☐ Seizures
- ☐ Stroke
- ☐

Mood/Affect
- ☐ Anxiety
- ☐ Depressed
- ☐ Irritable
- ☐ Nervous
- ☐ Tired
- ☐ Trouble sleeping

MEN only:
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Painful intercourse
- ☐ Sore on penis
- ☐ **Other:** _____

WOMEN only:
- ☐ Abnormal mammogram
- ☐ Abnormal pap smear
- ☐ Bleed between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Other: _____

Age at first menstrual cycle: _____
Age at menopause: _____
Date of last mammogram: _____
Date of last pap smear: _____
Normal: ☐ Y ☐ N _____
Hormone Replacement ☐ Y ☐ N _____
If Yes, how long: _____
Oral Contraceptives : ☐ Y ☐ N
If Yes, how long: _____
DepoProvera ☐ Y ☐ N:
Fertility Rx : ☐ Y ☐ N
Antiestrogen : ☐ Y ☐ N
Hysterectomy : ☐ Y ☐ N, Age: _____
Ovaries removed: ☐ Y ☐ N;
☐ 1 ☐ both

Pregnancies
Pregnant? ☐ Y ☐ N
#of pregnancies _____
#of children _____
#of miscarriages _____
Abortion _____
Age at 1st live birth: _____
Did you breastfeed? ☐ Y ☐ N
If Yes, how long? _____
Bra size _____
Last menstrual period _____
Other: _____

Hematology
- ☐ Blood clot
- ☐ Blood disorder
- ☐ Lupus/scleroderma/ Collagen vascular disease

Explain any of the above if necessary:

_____

_____

Family History

Are you adopted? ☐ **Yes** ☐ **No**. **Are you Ashkenazi (German/Eastern European) Jewish?** ☐ **Yes** ☐ **No**.

Race/Ethnicity _____

Mother's ancestry_____ **Father's Ancestry**_____

Family History Fill in health information about your family

Relation	Age	State of Health	Age at death	Cause of death	Check (✓) if your blood relatives had any of the following: *Disease*		*Relationship to you*
Father						Arthritis, gout	
Mother						Asthma, hay fever	
Brothers						Bleeding	
						Cancer (*also see below*)	
						Chemical dependency	
						Diabetes	
						Heart Disease	
						Hypertension	
Sisters						Kidney disease	
						Mental illness	
						Problems with anesthesia	
						Stroke	
						Thyroid	
						TB	

Please list all blood relatives in your immediate family who have had any form of cancer (parent, sibling, child):

Relationship to you	Type of Cancer	Approximate age at diagnosis

Please list all blood relatives in your extended family who have had any form of cancer (parent, sibling, child):

Your Mother's side of the family		
Relationship to you	**Type of Cancer**	**Approximate age at diagnosis**
Your Father's side of the family		
Relationship to you	**Type of Cancer**	**Approximate age at diagnosis**

History of Prior Radiation: Where given?_____**What year?**_____**Site:** _____

Prescription Medications and Supplements

Drug Name	Dose	Freq.	Drug Name	Dose	Freq.

Drug Reaction/allergy: _____

Other allergies: _____

_____

Signature of Patient:_____Date_____

Signature of Physician:_____Date_____

Signature of Patient:_____Date_____

Signature of Physician:_____Date_____

Signature of Patient:_____Date_____

Signature of Physician:_____Date_____

Signature of Patient:_____Date_____

Signature of Physician:_____Date_____