SWEDISH
CANCER INSTITUTE

SCI PATIENT INFORMATION

Today's Date:_____

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

Social Security ____-____-____ **Marital status** **Single** ☐ **Married** ☐ **Separated** ☐ **Widow(er)** ☐ **Dependent** ☐ **Domestic Partner** ☐

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

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

Pharmacy_____**Location:**_____**Phone #:**_____

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		Past	Current		Past	Current
AIDS			Emphysema					
Alcoholism			Glaucoma			Multiple sclerosis		
Anemia			Goiter			Pacemaker		
Anesthesia problems			Gout			Pneumonia		
Anxiety			Heartburn/reflux			Polio		
Arthritis			Heart disease			Prostate problem		
Asthma			Heart murmur			Radiation Therapy		
Bleeding disorders			Hepatitis			Dates:_____		
Blood transfusion			Herpes			Rheumatic fever		
Dates:_____			High blood pressure			Seizures		
Breast lump			High cholesterol			Stroke		
Bronchitis			HIV positive			Thyroid disease		
Cancer:_____			Infertility			Tuberculosis		
Chemical dependency			Kidney disease			Ulcers		
Chicken pox			Liver disease			Vaginal infection		
Depression			Migraine headache			Venereal disease		
Diabetes			Measles/mumps					
Eating Disorders-Anorexia/Bulemia			MRSA					

Patient Name: _____

Smoking	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 I2 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
- ☐

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
- ☐

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

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

Neurological
- ☐ Balance problems
- ☐ Dizziness
- ☐ Falls
- ☐ Headache
- ☐ 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 _____
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: _____

Patient Name: _____

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**

Patient Name: _____

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: _____