UFHealth
CANCER CENTER
ORLANDO HEALTH

Patient Name:	
MR#:	
Physician:	
DOB:	Date:

HEALTH INVENTORY

(Patients complete on initial consult)

Patient Name:_____
Person Completing the Form:_____
Primary Care Physician and phone number:_____
Referring Physician and phone number:_____
Please list all other physicians involved in your care:_____

Current Medical History:
What is the health problem that has brought you here today? _____
_____
When did this problem begin? _____
Have you received any treatment for this problem? Yes ❑ No ❑
List type of treatment, where and when it was provided. Have you received Chemotherapy or Radiation before?
_____
_____
_____

Past Medical History: (Please list all: i.e. heart problems, high blood pressure, diabetes, cancers, bleeding disorders, weight loss/gain)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please provide more information below for any of the conditions or illnesses you listed above.
_____
_____
Past Surgical History: Please include type of surgery, date, and facility where it was performed.
_____
_____

Social History: Preferred Language_____
Best learning style: (please check all that apply)
❑ 1 on 1 instruction ❑ Classroom/Group ❑ Video ❑ Audio ❑ Printed Materials

1. Marital Status

❑ Single	❑ Separated
❑ Married	❑ Significant Other
❑ Divorced	❑ Widowed

2. Do you have dependents? ❑ Yes ❑ No
3. Home situation/support

a) Do you have friends or family to help you with your care? Yes or No _____
b) Do you have friends of family who are dependent on you for care? Yes or No _____
c) Is there current abuse /neglect/domestic or family violence? Yes or No _____

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Do you use or have you ever used the following products:

Alcohol	Yes ❑ No ❑	Year Quit_____	Type_____	Years Used_____
Cigarettes/Cigars/ Pipes	Yes ❑ No ❑	Year Quit_____	Packs/Day_____ Amount/Day_____	Years Used_____
Chewing Tobacco /Snuff/Dip	Yes ❑ No ❑	Year Quit_____	Amount/Day_____	Years Used_____
Marijuana/Street Drugs	Yes ❑ No ❑	Year Quit_____	Type_____	Years Used_____

Work History:

1. Are you employed? Yes ❑ No ❑ Type of Work: _____
2. ❑ Full Time ❑ Part Time ❑ Retired ❑ Student
3. If no, do you plan to return to employment? _____
4. If you have had any exposure to radiation, chemicals, pesticides or industry hazards, what kind?

_____

Family History: 1. Has any member of your family (blood relatives) been diagnosed with cancer or blood disorders? Yes ❑ No ❑

Relative Kind of Cancer Age when diagnosed Still living/Age at death

_____

_____

_____

Please list all **Allergies below:**

Name	Reaction	When

Current Medications (include prescriptions, over the counter, vitamins, herbals)

Name of Medication	Dose	How often	Reason for taking	Length time taken

Pharmacy:_____ **Phone Number:**_____

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Tuberculosis Assessment (check if Yes):

- ❑ (3 points) Cough for longer than 2 weeks
- ❑ (2 points) Fevers or night sweats
- ❑ (2 points) Recent unexplained weight loss of > 10 lbs
- ❑ (2 points) Recent exposure to T.B.
- ❑ (5 points) Active T.B. or history of T.B. with unfinished therapy
- ❑ (2 points) Jail in the past 2 years
- ❑ (5 points) Blood in sputum
- ❑ (1 point) Homeless or living in a shelter
- ❑ (1point) Foreign born (Asia, E. Europe, Latin America, Africa)
- ❑ (2 points) HIV positive

Total Points_____

Recent Exposure to Communicable Diseases: (check if yes)

- ❑ Chicken Pox
- ❑ Measles
- ❑ Mumps
- ❑ Other:_____
- ❑ Date of Exposure:_____

Adult Immunizations: (check if yes)

- ❑ Hepatitis Date:_____
- ❑ Pneumococcal Date:_____
- ❑ H Flu Date:_____

Pain: Do you have pain? ❑ Yes ❑ No

Where is the pain located? _____

How long have you had the pain? _____

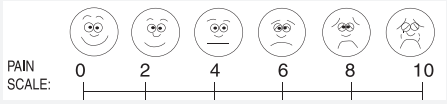
Is your pain: ❑ Intermittent ❑ Chronic

❑ Constant ❑ Acute

Describe your pain? _____

❑ Aching	❑ Burning
❑ Cramping	❑ Dull
❑ Knife-like	❑ Phantom
❑ Pressure	❑ Prickling
❑ Pulling	❑ Radiating
❑ Sharp	❑ Shooting
❑ Stabbing	❑ Tingling
❑ Other:	❑ Throbbing

Rate your pain from 0 to 10: (0=no pain to 10= excruciating pain) #_____



What relieves the pain? (Cold, Heat, Medications, Relaxation, Distraction, Music, Position, Massage, Other?)_____

What makes the pain worse?_____

Fatigue: (tiredness)

Please rate your fatigue from 0 to 10:

0= No fatigue
1-3 = Mild fatigue
4-7 = Moderate fatigue
7-9 = Extreme fatigue
10 = Worst, disabling

Your Fatigue = _____

Is your fatigue new or chronic? _____

What lessens the fatigue:

Rest ❑ Exercise ❑	Sleep ❑ Energy ❑ Conservation	Food ❑ Other____

What increases the fatigue:

Activity ❑	Stress ❑	Medications ❑	Other❑

Falls: Have you fallen or almost fallen recently?

_____

Demographics:

1. Race/Ethnicity: ❑ White, Anglo, Caucasian ❑ Spanish Origin (Hispanic) ❑ Black (African American) ❑ Asian /Pacific Islander ❑ American Indian/Native American ❑ Other (specify)_____

Would you like to meet with:

Counselor or Social Services Yes ❑ No ❑ Nutritionist Yes ❑ No ❑

Pastoral Care Yes ❑ No ❑ Financial Counselor Yes ❑ No ❑

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Advanced Directives:

Do you have a Living Will? Yes ❑ No ❑ N/A ❑ (less than 18 years old)
If No, would you like information? Yes ❑ (information given and discussed) No ❑
If Yes, can we have a copy of the Living Will for Record? Yes ❑ No ❑
Do you have a Healthcare Surrogate/Proxy? Yes ❑ No ❑ N/A ❑ (less than 18 years old)
Name of Healthcare Surrogate/Proxy? _____
If No, would you like more information? Yes ❑ No ❑
If Yes, can we have a copy of Healthcare surrogate/Proxy designation for Record? Yes ❑ No ❑
Do you have a Do Not Resuscitate Order? Yes ❑ No ❑ If Yes, please show your physician.

PLEASE CHECK YES OR NO IF YOU ARE HAVING ANY OF THE FOLLOWING NOW:

Head/Ears/Eyes/Nose/	YES	NO	COMMENTS: for clinical staff only
Headaches			
Sinus problems			
Hearing problems / ear pain			
Eye or Vision problems			
Nose Bleeds / drainage			
Teeth (do you have dentures) or gum problems			
Problems: eating ❑ chewing ❑ swallowing ❑			
Mouth or throat sores			
Hoarseness / change in voice			
Lungs			
Wheezing or asthma			
Cough			
Shortness of breath			
Difficult breathing			
Bloody phlegm or sputum			
Using oxygen			
Heart			
Chest pain			
Fast or irregular heartbeat			
Dizziness or fainting			
Breast			
Tenderness or discomfort			
Date of last mammogram: _____			
Skin changes			
Lumps			
Nipple discharge			
Prior breast biopsies and how many			

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	YES	NO	COMMENTS: for clinical staff only
Gastrointestinal			
Cramping or stomach pain			
Date of last Colonoscopy: _____			
Change in appetite or diet			
Nausea or vomiting			
Indigestion or heartburn			
Constipation			
Diarrhea (frequent watery stools)			
Loss of bowel control			
Blood in stools or black stools			
Gas or bloating			
Hemorrhoids / rectal pain			
Genitourinary			
Burning or pain with urination			
Problems starting or stopping your urine flow			
Loss of bladder control			
Burning or pain with urination (passing urine)			
Blood in urine			
(Male)Difficulty maintaining or obtaining erection			
(Male) Enlarged prostate			
(Male) Date of last prostate exam: _____			
Reproduction			
Painful intercourse			
Are you sexually active			
Planning to have future children			
(Female) Number of: • living children _____ • pregnancies _____ • abortions _____ • miscarriages _____			
(Female) Possibly pregnant			
(Female) Age at first menses			
(Female) First day of last menstrual period _____			
(Female) Heavy menstrual periods			
(Female) Bleeding between menstrual periods			
(Female) Hot flashes			
(Female) Last Pap Smear _____			
(Female) Using birth control? How long? _____ Type? _____			
(Female) Age at menopause _____			
(Female) Hormone replacement therapy? How long?___			
Extremities			
Back pain			

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	YES	NO	COMMENTS: for clinical staff only
Assistive devices: (wheelchair/cane/walker)_____			
Swelling of arms or legs			
Joint problems			
Difficulty walking			
Difficulty bathing, dressing, taking care of yourself			
Weakness or fatigue			
Piercings			
Tattoos			
Skin			
Bruise easily			
Open sores			
Slow healing wounds			
Rashes or skin irritations			
Fever or chills			
Neurological			
Night sweats			
Memory problems or memory loss			
Numbness or tingling			
Dizziness			
Fainting			
Speech problems			
Feeling hopeless or helpless			
Do you have seizures? • What are they like? _____ • How long do they last? _____ • What makes them better? _____ • Are you satisfied with the degree of seizure control? _____ • Do you have side effects from your seizure medications? _____			
Mood			
Sad or depressed			
Worried or anxious			
Exercise			
Do you exercise regularly? How much? _____			

Physical Exam Findings: (for clinical staff only)

BP:_____ HR:_____ RR:_____

INTERPRETER ONLY

(Please Print)

Name: _____ Agency: _____

Telephone:_____ Language: _____