



LINE UP PATIENT I.D. LABEL HERE

# ORLANDO HEALTH®

Mailing Address: 1414 Kuhl Ave. • Orlando, FL 32806

## GENERAL ONCOLOGY: HEALTH INVENTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Location/Phone #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Location/Phone #: \_\_\_\_\_

HR: \_\_\_\_\_ BP: \_\_\_\_\_ RR: \_\_\_\_\_ Temperature: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ (kg)

**Past Cancer History** Have you ever been diagnosed with cancer before? No Yes

Type of Cancer	Where treated (Doctor/Hospital/City)	When (Dates)

### Family History of Cancer

Are you adopted?	No	Yes	Has any member of your family (blood relative) been diagnosed with cancer?	No	Yes
Relative			Type of Cancer	Age when diagnosed	Alive
					No Yes
					No Yes
					No Yes
					No Yes

### Past Radiation History

Have you ever received other radiation therapy or radioactive iodine in the past? No Yes Date: \_\_\_\_\_

### Past Chemotherapy History

Have you ever received chemotherapy for another condition in the past? No Yes Date: \_\_\_\_\_

### Past Surgical History

Please list all surgeries:			Date:
Any implanted devices (pacemakers, pumps, etc.)	No	Yes	

### Past Medical History

Please add any additional medical issues:	Date:

### Gynecologic History

Age at first menses: \_\_\_\_\_ Are you possibly pregnant now? No Yes Are you using birth control? No Yes

Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_ Number of abortions: \_\_\_\_\_

Your age at first live birth: \_\_\_\_\_ Last menstrual period: \_\_\_\_\_ Age at menopause: \_\_\_\_\_

Have you used hormone replacement therapy? No Yes How long: \_\_\_\_\_

Last gynecologic examination: \_\_\_\_\_ Last Pap smear: \_\_\_\_\_

### Fertility Preservation

Are you planning to have children in the future?	No	Yes	Would you like more information about protecting your ability to have children in the future (fertility preservation procedures)?	No	Yes



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**Allergies** Do you have any allergies? No Yes

Drug Name / Allergen	Type of Reaction

### Medications

Please list all medication you are currently taking (including prescriptions, over the counter, vitamins, herbal supplements, alternative medicines, etc.)

Prescription Medications and Doses	Other Medications, Vitamins, Supplements, etc.

Pharmacy Name: \_\_\_\_\_ Pharmacy Location/Phone #: \_\_\_\_\_

### General Health Review

Constitutional/Nutrition	No	Yes	Gastrointestinal	No	Yes
<b>Lack of Appetite</b>			Do you have stomach or bowel problems?		
<b>Weight Loss/Gain</b>			<b>Nausea</b>		
<b>Fevers</b>			<b>Vomiting</b>		
<b>Chills</b>			Vomiting blood		
<b>Night Sweats</b>			Stomach cramping / pain		
<b>Fatigue</b>			Heartburn		
Mild Fatigue: Improves with rest			<b>Constipation</b>		
Moderate Fatigue: Does not improve with rest			Diarrhea		
Severe Fatigue: Does not improve with rest and limits taking care of self			Blood in stool		
<b>Eyes</b>	<b>No</b>	<b>Yes</b>	Loss of bowel control		
Do you have any eye problems?			Jaundice or yellow skin / eyes		
Blurry vision			Hemorrhoids / rectal pain		
Decreased vision			Colonoscopy? Date:		
Dry eye(s)			Other:		
Painful eye(s)			<b>Genitourinary</b>	<b>No</b>	<b>Yes</b>
Other:			Do you have urinary problems?		
<b>Ear/Nose/Mouth/Throat</b>	<b>No</b>	<b>Yes</b>	Urinary frequency		
Do you have ear/nose or throat problems?			Urinary urgency		
Decreased hearing			Burning on urination		
Ringing in the ears			Blood in urine		
Ear pain			Loss of urinary control		
Nose bleeding			Are you sexually active?		
Problems eating/chewing/swallowing			Other:		
Do you have dentures?			<b>Male</b>	<b>No</b>	<b>Yes</b>
Hoarseness/voice changes			Difficulty with erection		
Facial weakness or numbness			Difficulty with ejaculation		
Other:			Enlarged prostate		
<b>Heart (Cardiovascular)</b>	<b>No</b>	<b>Yes</b>	Other:		
Do you have heart problems?			<b>Female</b>	<b>No</b>	<b>Yes</b>
Chest pain			Hot flashes		
Pain on exertion			Pelvic pain		
Dizziness/fainting			Vaginal bleeding		
Irregular heart beat			Vaginal discharge		
Hypertension/High Blood Pressure			Other:		



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<b>Respiratory</b>	<b>No</b>	<b>Yes</b>	<b>Skin/Breast</b>	<b>No</b>	<b>Yes</b>
Do you have breathing problems?			Do you have any skin problems?		
Cough			Rash		
Bloody phlegm / bloody sputum			Itching		
<b>Shortness of breath</b>			Open sores		
Difficulty breathing / pain when breathing			Nail Changes		
Do you use oxygen?			Other:		
Other:			Do you have any breast problems?		
<b>Muscle or bone (Musculoskeletal)</b>	<b>No</b>	<b>Yes</b>	Breast lump		
Do you have any bone/muscle problems?			Breast pain		
Back/neck pain			Breast skin color change		
Joint pains			Breast skin break/ulcers		
Muscle aches/pains			Nipple discharge		
Leg weakness			Armpit lump		
<b>Changes in mobility?</b>					
Changes in activities of daily living (Bathing, Eating, Self-care)			<b>Endocrine</b>	<b>No</b>	<b>Yes</b>
			Do you have any endocrine problems?		
<b>Neurological</b>	<b>No</b>	<b>Yes</b>	Excessive thirst		
Do you have any neurological problems?			Frequent urination		
Headaches			Mood swings		
Numbness or tingling			Cold intolerance		
Memory problems			Heat intolerance		
Dizziness / vertigo			Goiter		
Seizures			Thinning hair, constipation, dry skin, tiredness (symptoms or low thyroid)		
Speech problems			Diabetic		
Weakness in face, arm or leg (not general tiredness)?			<b>Hematologic/Lymphatic</b>	<b>No</b>	<b>Yes</b>
Other:			Do you have blood or lymph problems?		
<b>Psychiatric</b>	<b>No</b>	<b>Yes</b>	Red or purple skin discolorations		
Do you have any psychiatric or emotional problems?			Prolonged or excessive bleeding		
Depression			Use of Aspirin or blood thinners		
Anxiety			Prior blood transfusions		
Difficulty sleeping			Lymphedema / arm or leg swelling		
Other:			Swollen or painful lymph nodes		
			Other:		
<b>Allergic / Immunologic</b>	<b>No</b>	<b>Yes</b>			
Do you have allergies or asthma?					
Seasonal allergies or hay fever					
Asthma					
Hives					
Dermatitis / skin reactions					
Other:					

### Reviewed By

Medical Assistant: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Nurse: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Physician/Midlevel: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

### INTERPRETER ONLY

(Please Print)

Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Telephone: \_\_\_\_\_ Language: \_\_\_\_\_

