| Patient name   | Date of Bi                                 | rth:                                   |
|--|--|--|
|  | HEALTH ASSES                               | <u>SSMENT</u>                          |
| ate:   |  |  |
| ge: Female:  | ☐ Male: ☐ Primary Languag                  | ge:                                    |
| eason for coming to office:  |  |  |
| ame of primary care physician:   |  | · · · · · · · · · · · · · · · · · · ·  |
| ames of your other physicians:   |  |  |
| ome telephone:   | Work telephone:                            | Cell phone:                            |
| PPRGCP   | TROPIONI REPRINCIPE AND AREA AREA          | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| me of drug   | IPTION MEDICATIONS (if not<br>Dose (in mg) | # of times per day                     |
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|  | Please continue on the back of s           | •                                      |
| ase list any over-the-counte   | r medications/vitamins you take:           |  |
| ase list any herbal medication   | ons, food supplements, teas:               |  |
|  | •  |  |
| you use any complementar   |  | ☐ Chiropractic ☐ Herbs/Naturopath      |
|  | ☐ Other                                    | <del></del>                            |
| Meditation ☐ Massage   |  |  |
| you have any allergies to m  | edications   Yes   No.                     |  |
| you have any allergies to m  |  |  |
| you have any allergies to mes, please list:  | edications   Yes   No.                     |  |
| you have any allergies to mes, please list:  nave an allergy to Latex (Ba            | edications                                 | condoms) □ Yes □ No                    |
| you have any allergies to mes, please list:  nave an allergy to Latex (Bass, explain | edications                                 |  |

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| Patient name   | Date of Birth:   |
|--|--|
| Diseas shoots which hest   | escribes your current state: (ECOG Performance Status Scale)               |
|  | arry on all pre-disease activities without restrictions.                   |
|  | y strenuous activity but ambulatory and able to perform light work.        |
|  | ble of all self-care but unable to work. Up and about >50% of waking hours |
|  | d self-care. Confined to bed or chair more than 50% of waking hours.       |
|  | Cannot perform any self-care. Confined to bed or chair.                    |
|  | MEDICAL HISTORY  |
| How do you rank your gene  | ral health?   Excellent   Good   Fair   Poor                               |
| Please list any surgeries yo   | ı have had in the past: (use additional paper if necessary)                |
| Approx Date  | Type of surgery Where  |
|  |  |
|  |  |
| 411111111111111111111111111111111111111  | <u> </u>   |
|  |  |
|  | <u> </u>   |
| · .  |  |
| Please list any chronic cond   | tions for which you see a physician: (use additional paper if necessary)   |
| Condition:   | Physician:   |
|  |  |
| - Lincoln Control Cont |  |
|  |  |
|  |  |
|  |  |
| Do you have a collagen vas   | ular disease (rheumatoid arthritis, scleroderma, lupus)? ☐ Yes ☐ No        |
|  |  |
| lave you ever had radiation  |  |
| Vhere?   | When?  |

| Eastern Connecticut Hematology and Oncology, 330 Washington Street #220, Norwich, CT 06360  |
|---|
| Patient name Date of Birth:   |
|   |
| FAMILY HISTORY  |
| List Any Cancer or Blood Disease and/or Cause of Death                                      |
| Mother:   Alive , age   Deceased at age   |
| Father:   Alive, age   Deceased at age  |
| Maternal Grandmother:   Alive , age   Deceased at age                                       |
| Maternal Grandfather:   Alive , age   Deceased at age                                       |
| Paternal Grandmother:   Alive , age   Deceased at age                                       |
| Paternal Grandfather:   Alive , age   Deceased at age                                       |
| Siblings: (Please list each separately. If more room is needed, please use separate sheet.) |
| : ☐ Alive, age ☐ Deceased at age  |
| :   Alive, age   Deceased at age  |
| :   Alive , age   Deceased at age   |
| : ☐ Alive , age ☐ Deceased at age   |
| : ☐ Alive , age ☐ Deceased at age   |
| Children: (Please list each separately. If more room is needed, please use separate sheet.) |
| : ☐ Alive , age ☐ Deceased at age   |
|   |
|   |

| : ☐ Alive , age                  | ☐ Deceased at age                                       |
|----------------------------------|---|
| : 🗆 Alive , age                  | □ Deceased at age                                       |
| : □ Alive , age                  | □ Deceased at age                                       |
| : ☐ Alive , age                  | □ Deceased at age                                       |
| Race/Ethnicity:                  |   |
| ☐ American Indian/Alaskan Native | ☐ Asian/Pacific Islander ☐ Black/not of Hispanic origin |
| □ Hispanic □ White/not of Hispa  | nic origin  |
| Religion :                       | <u>.</u>  |
| Marital status:                  |   |
| ☐ Married ☐ Partnered            | ☐ Single ☐ Divorced ☐ Widow                             |
| Who do you live with?            |   |
| Name:                            | Relationship: Cell Phone:                               |
|                                  | Relationship: Cell Phone:                               |
| Housing:   Single Level          | ☐ Multi-level ☐ Assisted Living ☐ Nursing Home          |

Housing:

|   |   | ashington Street #220, Norwich, CT 06360  Birth: |
|---|---|--|
|   |   | Phone:   |
|   | oort or help: ☐ same as above             |  |
| Name:   | Relationship:                             | Cell Phone:                                      |
| Name:   | Relationship:                             | Cell Phone:                                      |
| Are you currently working?                                |   |  |
| □Yes □ No   | ☐ Part-Time ☐                             | Full-Time   Volunteer                            |
| Do you plan to return to work?                            | '□ Yes □ No What do yo                    | u do/ did you do?                                |
| Are you able to: Shop for sel                             | f ☐ Yes ☐ No Cook for self                | ☐ Yes ☐ No Wash self ☐ Yes ☐ No                  |
| Transportation:   Whee                                    | elchair 🗆 Cane 🗆 Walk                     | er   Crutches   Artificial Limb                  |
| ☐ Drive Self ☐ Family                                     | Assistance   Wheelchair S                 | ervices   Ambulance   Volunteer Driver           |
| Name of driver/service:                                   |   | Phone:   |
| Check if you use of any of the  ☐ VNA ☐ Private agency he | -   | vork □ Physical Therapy □ Speech Therapy         |
| Check if you receive any of the                           | following benefits?                       |  |
| ☐ Disability ☐ Medicaid                                   | ☐ State assistance ☐ Une                  | mployment benefits                               |
| -   | ☐ Never used ☐ Curi<br># of packs per day |  |
| Chewing Tobacco - ☐ Never<br>Age started                  | used   Current use Age quit               | ☐ Previous use                                   |
| Do you currently drink alcohol?                           | ☐ Yes How much:                           |  |
|   | st?   Yes How much:                       |  |
| Do you drink beverages contai                             | ning caffeine?   Yes How m                | nuch:  |
|   | REVIEW OF SYSTI                           | <u>EMS</u>                                       |
| g   | ENERAL                                    |  |
| Please check if you have any o                            | f the following: ☐ Fatigue ☐              | Fever ☐ Sweats                                   |
| EYE. E  | AR. NOSE. THROAT. MOUTH                   | □ NO PROBLEM                                     |
| Any problems with:   Vision                               | ☐ Hearing ☐ Sinuse                        | s   Dry mouth   Teeth/Gums                       |
| ☐ Altered   | I taste or smell                          | □ Swallowing □ Sore Throat                       |

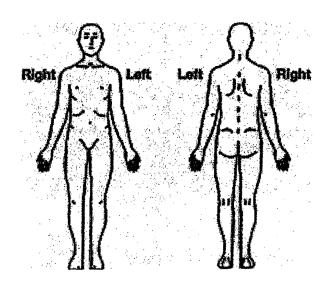
| Eastern Connecticut Hematology and Onco                | ology, 330 Washington Street #220, Norwich, CT 06360 |
|--|--|
| Patient name   | Date of Birth:                                       |
| Do you have dentures: □ Yes □ No □                     | l Upper □ Lower □ Partial                            |
| Do your dentures fit properly? ☐ Yes ☐                 | ] No Explain   |
| HEART  | □ NO PROBLEM   |
| Any problems with:                                     |  |
|  | Fainting   Irregular heartbeat   Palpitations        |
| ☐ Swollen ankles ☐ Other                               |  |
| Do you have a pacemaker or defibrillator?   — Yes      | □ No   |
| Any problems with:                                     | □ NO PROBLEM   |
| • •  |  |
|  | ☐ Walking ☐ Climbing stairs # of flights             |
|  | Liters per minute \( \text{D} \) No                  |
|  |  |
| GASTRO-INTESTIN Any problems with:                     | NAL ONO PROBLEM                                      |
| ☐ Constipation ☐ Diarrhea ☐ Change                     | in bowel pattern                                     |
| ☐ Blood in stools ☐ Abdominal discomfort               | ☐ Nausea ☐ Vomiting                                  |
| ☐ Change in appetite ☐ Indigestion ☐ Re                | eflux  |
| Do you have a colostomy? ☐ Yes ☐ No                    |  |
| Date of last bowel movement                            | Average frequency                                    |
|  |  |
| NUTRITION ASSESSMEN                                    | NI O PROBLEM   |
| Has your weight changed in the past 6 months?          | ☐ Yes ☐ No Average weight last year?                 |
| Number of pounds gained: or                            | Number of pounds lost:                               |
| Haw in your appoints?     Eventlent                    | □ Foir □ Boor  |
| How is your appetite? ☐ Excellent ☐ Good               | □ Fair □ Poor  |
|  |  |
| Check the words that describe your diet:               | Diabatic Cl. Eluid restricted                        |
|  | Diabetic □ Fluid restricted  Diesterol □ Low fat     |
| ☐ Kosher ☐ Low calorie ☐ Low cho                       |  |
| Have you changed your diet due to illness or condition |  |
|  |  |
| If yes, describe                                       |  |
| 5  |  |
| <b>,</b>   |  |

| Eastern Connecticut Hematology and Oncology, 330 Washington Street #220, Norwich, CT 06360                                   |
|--|
| Patient name Date of Birth:  |
| Do you have any food allergies? ☐ Yes ☐ No   |
| If yes, describe   |
| Are you using food supplements?   Yes   No Type:   |
| URINARY TRACT/SEXUAL ORGANS ☐ NO PROBLEM Check here if you are experiencing any of the following kidney or bladder problems: |
| □ Urinating frequently – If yes, □ At night only or □ All the time   |
| ☐ Incontinence ☐ Burning on urination ☐ Blood in urine ☐ Catheter in place ☐ Urostomy  |
| □ Other  |
| Sexual function: Do you have problems with: ☐ Libido/Desire ☐ Erection ☐ Orgasm  |
| For women only:  Age began menstruation: Date of last menstrual period Age at menopause:                                     |
| Have you ever used oral contraceptives:   Yes  No If yes, how longmonths/years when stopped:                                 |
| Have you ever used hormone-replacement therapy:   Yes  No If yes, how longmonths/years when stopped:                         |
| Is it possible you could be pregnant at this time: ☐ Yes ☐ No  |
| Age at first pregnancy: Did you breast-feed   Yes   No If yes, how long?   |
| MUSCLES & BONES  |
| Do you exercise on a regular basis:  |
| Check here if you experience any of the following:   |
| ☐ Back pain ☐ Arthritis - which joints   |
| ☐ Numbness/Tingling ☐ Other joint pain – which joints  |
| ☐ Weakness - ☐ Generalized ☐ Specific site   |
| CVIN TIMO DECEMBER   |
| SKIN ☐ NO PROBLEM  Do you have any: ☐ Bruises ☐ Open areas ☐ Rashes ☐ Redness  |
| Do you have a history of skin cancer If yes, what type What  |
| ☐ Other If other, describe   |
| NERVOUS SYSTEM   |
| Check if you experience any of the following:  |
| ☐ Depression ☐ Anxiety ☐ Other Psychological Diagnosis:Hospitalized ☐ Yes ☐ No   |
| ☐ Headaches ☐ Problems with coordination ☐ Weakness/Paralysis  |

| Eastern Connecticut Hematology and Oncology, 330 Washington Street #220, Norwich, CT 0636 |
|---|
| Patient name Date of Birth:   |
| ☐ Confusion ☐ Memory problems ☐ Insomnia/trouble sleeping                                 |
| Do you use sleeping aids? ☐ Yes ☐ No  |
| PREVENTION  |
| Please indicate the date of your last examination and who performed:                      |
| Regular physical examination:   |
| Clinical breast examination:  |
| Monthly breast self-examination:  |
| Mammogram:  |
| Pap smear:  |
| Clinical prostate examination:  |
| Date of last colonoscopy:   |
| Bone Density  |
| Dermatology skin exam   |

## COMFORT/PAIN

Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?  $\Box$  Yes  $\Box$  No - please skip to Page 9



On the diagram, shade in the areas where you feel pain. Put an  $\boldsymbol{X}$  on the area(s) that hurt(s) the most.

| Patient name Date of Birth:  Please rate your pain by circling the one number that best describes your pain at its worst in the past 24 hours.  Please rate your pain by circling the one number that best describes your pain at its least in the past 24 hours.  Please rate your pain by circling the one number that best describes your pain on the average.  Please rate your pain by circling the one number that best describes your pain on the average.  Please rate your pain by circling the one number that tells how much pain you have right now.  In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  | •        | Eastern Connecticut Hematology and Oncology, 330 Washington Street #220, Norwich, CT 06360   |
|--|----------|--|
| Please rate your pain by circling the one number that best describes your pain at its least in the past 24 hours.  Please rate your pain by circling the one number that best describes your pain on the average.  Please rate your pain by circling the one number that tells how much pain you have right now.  In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  |          | Patient name Date of Birth:  |
| Please rate your pain by circling the one number that best describes your pain at its least in the past 24 hours.  Please rate your pain by circling the one number that best describes your pain on the average.  Please rate your pain by circling the one number that tells how much pain you have right now.  In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  |          | rate your pain by circling the one number that best describes your pain at its worst in the past 24  |
| Please rate your pain by circling the one number that best describes your pain at its least in the past 24 hours.  Please rate your pain by circling the one number that best describes your pain on the average.  Please rate your pain by circling the one number that tells how much pain you have right now.  In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  SUPPORT   | nours.   |  |
| Please rate your pain by circling the one number that best describes your pain on the average.  Please rate your pain by circling the one number that tells how much pain you have right now.  In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  SUPPORT  |          | in representation of the second of the secon |
| Please rate your pain by circling the one number that best describes your pain on the average.  Please rate your pain by circling the one number that tells how much pain you have right now.  In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  SUPPORT  |          | And the second of the second o |
| Please rate your pain by circling the one number that best describes your pain on the average.  Please rate your pain by circling the one number that tells how much pain you have right now.  In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  SUPPORT  | Dlongo   | rate your pain by circling the one number that best describes your pain at its least in the past 24 hours  |
| Please rate your pain by circling the one number that best describes your pain on the average.  Please rate your pain by circling the one number that tells how much pain you have right now.  In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  SUPPORT  | Please   |  |
| Please rate your pain by circling the one number that tells how much pain you have right now.  If the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  SUPPORT  |          | and the second of the second o |
| Please rate your pain by circling the one number that tells how much pain you have right now.  If the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  SUPPORT  |          |  |
| Please rate your pain by circling the one number that tells how much pain you have right now.  In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  SUPPORT  | Please   | rate your pain by circling the one number that best describes your pain on the average.  |
| Please rate your pain by circling the one number that tells how much pain you have right now.  In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  SUPPORT  |          |  |
| In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  SUPPORT   |          | and the second of the second o |
| In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  SUPPORT   |          |  |
| In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.  What treatments or medications are you receiving for pain?  SUPPORT   | Please   | ate your pain by circling the one number that tells how much pain you have <b>right now.</b>   |
| In the past 24 hours, how much relief have pain treatments or medications provided. Please circle the one percentage that most shows how much relief you have received.    Years   Yea | 0        |  |
| percentage that most shows how much relief you have received.  |          | je i sa provincija i sa provin |
| percentage that most shows how much relief you have received.  IND  What treatments or medications are you receiving for pain?  SUPPORT  |          |  |
| What treatments or medications are you receiving for pain?   |          |  |
| SUPPORT  |          |  |
| SUPPORT  |          | Complete:  |
| SUPPORT  |          |  |
| SUPPORT  | What tre | atments or medications are you receiving for pain?   |
|  |          |  |
|  |          |  |
| Do you have any religious or cultural practices we should be aware of during your treatment?   |          | SUPPORT  |
| To you have any rengious of canalar processor for circular or animg your nearling  | Do you h | ave any religious or cultural practices we should be aware of during your treatment?   |
| ☐ Yes ☐ No If yes, please explain:   | ☐ Yes    | □ No If yes, please explain:   |
| Do you have any concerns about how your illness will affect your family, job, and/or financial resources?  |          |  |
| ☐ Yes ☐ No If yes, please explain:  Have there been any big changes in your life in the past year? ☐ Yes ☐ No  |          |  |

| Eastern Connecticut Hematology and Oncology, 330 Washington Street #220, Norwich, CT 06360   |
|--|
| Patient name Date of Birth:  |
| ☐ Divorce ☐ Loss of job ☐ Death of loved one ☐ Move of household ☐ Other  Do you feel safe in your home? ☐ Yes ☐ No  |
| Do you have an Advance Directive, Living Will, or Durable Power of Attorney for Health Care  |
| ☐ Yes (Please bring to office so we may make a copy) ☐ No ☐ Don't know what this is  |
| Is there anything else about you or your current health or situation that you feel we should know? Any service you are particularly interested in? (genetics testing, support groups, counseling, nutrition, etc?) |
| Your signature:Date:   |
| If completed by someone other than the patient:  |
| Name:Relationship:   |
| Physician Signature: Date:   |

| Patient name  | Date of Birt   | th:                                   |
|---|--|---------------------------------------|
|   | HEALTH ASSESS  | <u>SMENT</u>                          |
| ate:  |  |                                       |
|   | e:   Male:   Primary Language  | ,                                     |
|   |  |                                       |
| ame of primary care physicians  |  |                                       |
|   |  | Cell phone:                           |
|   |  |                                       |
| PRESCI  | RIPTION MEDICATIONS (if not  | bringing a list with you)             |
| ame of drug   | Dose (in mg)   | # of times per day                    |
|   |  |                                       |
|   |  |                                       |
|   |  | <u> </u>                              |
|   |  |                                       |
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|   | · .  |                                       |
|   |  | ·                                     |
|   | (Please continue on the back of sh                                     | eet as needed)                        |
| ease list any over-the-count  | er medications/vitamins you take: _                                    |                                       |
| ,   |  |                                       |
| sass not any nordal misuloal  | iono, iood supplements, teas.  |                                       |
|   | ny treatments: T Acununcture T   | ☐ Chiropractic ☐ Herbs/Naturopathy    |
| you use any complementa   | ry treatments. $\square$ Acupuncture $\square$                         |                                       |
|   |  |                                       |
| Meditation ☐ Massage  | □ Other  |                                       |
| Meditation ☐ Massage you have any allergies to n  | ☐ Othernedications ☐ Yes ☐ No  |                                       |
| Meditation □ Massage you have any allergies to n es, please list:   | ☐ Othernedications ☐ Yes ☐ No  |                                       |
| Meditation ☐ Massage you have any allergies to n es, please list: have an allergy to Latex (B             | ☐ Othernedications ☐ Yes ☐ No  | condoms) 🗆 Yes 🗆 No                   |
| Meditation ☐ Massage you have any allergies to n es, please list: have an allergy to Latex (B es, explain | ☐ Othernedications ☐ Yes ☐ No<br>eand-Aids, rubber gloves, balloons, c | condoms)                              |
| Meditation ☐ Massage you have any allergies to n es, please list: have an allergy to Latex (B es, explain | ☐ Othernedications ☐ Yes ☐ No<br>eand-Aids, rubber gloves, balloons, c | condoms) 🗆 Yes 🗆 No                   |

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| Eastern Connecticut ł          |   | nington Street #220, Norwich, CT 06 |
|--------------------------------|---|-------------------------------------|
| Patient name                   | Date of Birth                           | h:                                  |
| Please choose which best de    | scribes your current state: (ECOG F     | Performance Status Scale)           |
| ☐ 0- Fully active. Able to car | ry on all pre-disease activities withou | it restrictions.                    |
| □1 – Restricted in physically  | strenuous activity but ambulatory an    | d able to perform light work.       |
| ☐ 2 – Ambulatory and capab     | le of all self-care but unable to work. | Up and about >50% of waking hou     |
| ☐ 3 – Capable of only limited  | self-care. Confined to bed or chair r   | more than 50% of waking hours.      |
| □4 – Completely disabled. C    | Cannot perform any self-care. Confin    | ed to bed or chair.                 |
|                                | MEDICAL HISTORY                         |                                     |
| How do you rank your genera    | l health?   Excellent   Good            | I □ Fair □ Poor                     |
| Please list any surgeries you  | have had in the past: (use additional   | l paper if necessary)               |
| Approx Date                    | Type of surgery                         | Where                               |
|                                |   |                                     |
|                                |   |                                     |
|                                |   |                                     |
|                                |   |                                     |
|                                |   |                                     |
|                                |   |                                     |
| ·                              | ons for which you see a physician: (    | • •                                 |
| Condition:                     |   | Physician:                          |
|                                |   |                                     |
|                                |   | ,                                   |
|                                | ·                                       |                                     |
|                                |   |                                     |
|                                |   |                                     |
|                                |   |                                     |
| o you nave a collagen vascu    | lar disease (rheumatoid arthritis, scle | eroderma, lupus)? 🛘 Yes 🔲 N         |
| ave you ever had radiation tr  | eatment? ☐ Yes ☐ No                     |                                     |
| in a ro 2                      | \A(I                                    |                                     |

| Eastern Connecticut Hematology and Oncolog | yy, 330 Washington | Street #220, | Norwich, ( | CT 06360 |
|--|--------------------|--------------|------------|----------|
| Delicators                                 | D :                |              |            | *        |
| Patient name                               | Date of Birth:     |              |            |          |

## **FAMILY HISTORY**

## List Any Cancer or Blood Disease and/or Cause of Death ☐ Alive , age \_\_\_\_ ☐ Deceased at age \_\_\_\_\_ Mother: Father: ☐ Alive, age \_\_\_\_ ☐ Deceased at age \_\_\_\_\_ Maternal Grandmother: Alive , age \_\_\_\_ Deceased at age \_\_\_\_ \_\_\_\_ Maternal Grandfather: Alive , age \_\_\_\_ Deceased at age \_\_\_\_ Paternal Grandmother: Alive , age \_\_\_\_ Deceased at age \_\_\_\_ ☐ Alive , age ☐ Deceased at age Paternal Grandfather: <u>Siblings</u>: (Please list each separately. If more room is needed, please use separate sheet.) : Alive , age Deceased at age \_\_\_\_\_ : 🛘 Alive , age 🔝 🗀 Deceased at age \_\_\_\_\_ : 🗆 Alive , age 🔝 🗅 Deceased at age \_\_\_\_\_ \_\_\_\_\_\_: Alive , age \_\_\_\_ Deceased at age \_\_\_\_\_ \_\_\_\_\_: Alive , age Deceased at age \_\_\_\_ Children: (Please list each separately. If more room is needed, please use separate sheet.) \_\_\_\_\_: Alive , age \_\_\_\_ Deceased at age \_\_\_\_\_ \_\_\_\_ \_\_\_\_\_: 🛘 Alive , age \_\_\_\_ 🗎 Deceased at age \_\_\_\_\_ \_\_\_\_\_: 🛘 Alive , age \_\_\_\_ 🗘 Deceased at age \_\_\_\_\_ : 🗆 Alive , age \_\_\_\_ 🗆 Deceased at age \_\_\_\_\_ Race/Ethnicity: ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Black/not of Hispanic origin ☐ Hispanic ☐ White/not of Hispanic origin ☐ Jewish Heritage ☐ Other Religion : \_\_\_\_\_\_ Marital status: ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widow Who do you live with? Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Housing: ☐ Single Level ☐ Multi-level ☐ Assisted Living ☐ Nursing Home

| Eastern Connecticut Hematology and Oncology, 330 Washi   | ngton Street #220, Norwich, CT 06360        |
|--|---|
| Patient name Date of Birth:  |   |
| If assisted living program or nursing home, please name:   | Phone:                                      |
| On whom do you rely for support or help: $\ \square$ same as above   |   |
| Name: Relationship:  | Cell Phone:                                 |
| Name: Relationship:  | Cell Phone:                                 |
| Are you currently working?   |   |
| ☐Yes ☐ No ☐ Part-Time ☐ Fu   | ıll-Time ☐ Volunteer                        |
| Do you plan to return to work? ☐ Yes ☐ No What do you do   | / did you do?                               |
| Are you able to: Shop for self ☐ Yes ☐ No Cook for self ☐ Yes  | Yes □ No Wash self □ Yes □ No               |
| Transportation: ☐ Wheelchair ☐ Cane ☐ Walker   | ☐ Crutches ☐ Artificial Limb                |
| ☐ Drive Self ☐ Family Assistance ☐ Wheelchair Service  | ces   Ambulance   Volunteer Driver          |
| Name of driver/service:  | Phone:                                      |
| Tobacco use: Cigarettes - ☐ Never used ☐ Current   | oyment benefits<br>smoker □ Previous smoker |
| Age started smoking # of packs per day Age  Chewing Tobacco - □ Never used □ Current use  Age started Age quit |   |
|  | CI No.                                      |
| Do you currently drink alcohol?   Yes How much:  Yes How much:   |   |
| Do you drink beverages containing caffeine?   Yes How much:  |   |
| REVIEW OF SYSTEMS  |   |
| GENERAL  |   |
| Please check if you have any of the following:   Fatigue  Fev  | ver 🗆 Sweats                                |
|  | NO PROBLEM                                  |
| Any problems with: ☐ Visìon ☐ Hearing ☐ Sinuses I  | ☐ Dry mouth ☐ Teeth/Gums                    |
| ☐ Altered taste or smell ☐ Mouth sores ☐ yes, describe:  | ☐ Swallowing ☐ Sore Throat                  |
|  |   |

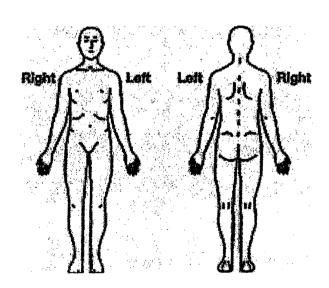
| Lastern Connecticut Hernatology and Oncology, 330 Washington Street #220, Norwich, CT 06360      |
|--|
| Patient name Date of Birth:  |
| Do you have dentures: □ Yes □ No □ Upper □ Lower □ Partial                                       |
| Do your dentures fit properly?   Yes   No Explain  |
| HEART  |
| Do you have a pacemaker or defibrillator?   Yes   No   |
| Any problems with:     Asthma  |
| ☐ Shortness of breath — ☐ At rest ☐ Walking ☐ Climbing stairs # of flights                       |
| Do you use oxygen?   Yes Hours per day Liters per minute   No                                    |
| GASTRO-INTESTINAL  |
| Date of last bowel movement Average frequency  |
| NUTRITION ASSESSMENT   |
| How is your appetite? ☐ Excellent ☐ Good ☐ Fair ☐ Poor   |
| Check the words that describe your diet: ☐ Regular ☐ Soft ☐ Liquid ☐ Diabetic ☐ Fluid restricted |
| ☐ Kosher ☐ Low calorie ☐ Low cholesterol ☐ Low fat   |
| ☐ Low salt ☐ Vegetarian ☐ Other  |
| Have you changed your diet due to illness or condition? □ Yes □ No                               |
| f yes, describe  |

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|--|--|--|--|--|
| Patient name Date of Birth:  |  |  |  |  |
| Do you have any food allergies?   Yes  No  If yes, describe  |  |  |  |  |
| Are you using food supplements?   Yes   No Type:   |  |  |  |  |
|  |  |  |  |  |
| <u>URINARY TRACT/SEXUAL ORGANS</u> ☐ <b>NO PROBLEM</b> Check here if you are experiencing any of the following kidney or bladder problems:       |  |  |  |  |
| ☐ Urinating frequently – If yes, ☐ At night only or ☐ All the time   |  |  |  |  |
| ☐ Incontinence ☐ Burning on urination ☐ Blood in urine ☐ Catheter in place ☐ Urostomy  |  |  |  |  |
| □ Other  |  |  |  |  |
| Sexual function: Do you have problems with: ☐ Libido/Desire ☐ Erection ☐ Orgasm  |  |  |  |  |
| For women only:  Age began menstruation: Date of last menstrual period Age at menopause:   |  |  |  |  |
| Have you ever used oral contraceptives:   Yes No If yes, how longmonths/years when stopped:  |  |  |  |  |
| Have you ever used hormone-replacement therapy:   Yes  No If yes, how longmonths/years when stopped:   |  |  |  |  |
| ls it possible you could be pregnant at this time: ☐ Yes ☐ No  |  |  |  |  |
| Age at first pregnancy: Did you breast-feed   Yes  No If yes, how long?  |  |  |  |  |
| MUSCLES & BONES  |  |  |  |  |
| Do you exercise on a regular basis:  |  |  |  |  |
| Check here if you experience any of the following:   |  |  |  |  |
| ☐ Back pain ☐ Arthritis - which joints   |  |  |  |  |
| ☐ Numbness/Tingling ☐ Other joint pain – which joints  |  |  |  |  |
| ☐ Weakness - ☐ Generalized ☐ Specific site   |  |  |  |  |
| SKIN □NO PROBLEM   |  |  |  |  |
| SKIN □ NO PROBLEM  Do you have any: □ Bruises □ Open areas □ Rashes □ Redness  Do you have a history of skin cancer □ If yes, what type □ What □ |  |  |  |  |
| □ Other If other, describe   |  |  |  |  |
|  |  |  |  |  |
| NERVOUS SYSTEM □NO PROBLEM   |  |  |  |  |
| Check if you experience any of the following:  |  |  |  |  |
| ☐ Depression ☐ Anxiety ☐ Other Psychological Diagnosis:Hospitalized ☐ Yes ☐ No   |  |  |  |  |
| ☐ Headaches ☐ Problems with coordination ☐ Weakness/Paralysis  |  |  |  |  |

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|--|
| Patient name Date of Birth:  |
| ☐ Confusion ☐ Memory problems ☐ Insomnia/trouble sleeping                                  |
| Do you use sleeping aids? ☐ Yes ☐ No   |
| PREVENTION   |
| Please indicate the date of your last examination and who performed:                       |
| Regular physical examination:  |
| Clinical breast examination:   |
| Monthly breast self-examination:   |
| Mammogram:   |
| Pap smear:   |
| Clinical prostate examination:   |
| Date of last colonoscopy:  |
| Bone Density   |
| Dermatology skin exam  |

## COMFORT/PAIN

Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?  $\Box$  Yes  $\Box$  No - please skip to Page 9



On the diagram, shade in the areas where you feel pain. Put an X on the area(s) that hurt(s) the most.

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|--|--|
| Patient name   | Date of Birth:   |
|  | at best describes your pain at its worst in the past 24  |
| hours.   |  |
|  | A Section of the sect |
| Please rate your pain by circling the one number th  | at best describes your pain at its <b>least</b> in the past 24 hours.  |
|  |  |
| Please rate your pain by circling the one number th  | at best describes your pain on the average.  |
|  | Laprication du la company de l |
| Please rate your pain by circling the one number the   | at tells how much pain you have <b>right now.</b>  |
| Discontinue de la companya della companya della companya de la companya della com |  |
| In the past 24 hours, how much <b>relief</b> have pain tre percentage that most shows how much relief you ha   | atments or medications provided. Please circle the one ave received.   |
|  |  |
|  |  |
| What treatments or medications are you receiving for   | or pain?   |
|  |  |
| , .  | <u>UPPORT</u>  |
| Do you have any religious or cultural practices we s  ☐ Yes ☐ No If yes, please explain:   |  |
| · · · · · · · · · · · · · · · · · · ·  |  |
|  | ill affect your family, job, and/or financial resources?   |
| Have there been any big changes in your life in the  |  |

| Eastern Connecticut Hematology and Oncology,   | 330 Washington Street #220, Norwich, CT 06360 |  |
|--|---|--|
| Patient name Date of Birth:  |   |  |
| ☐ Divorce ☐ Loss of job ☐ Death of loved one ☐ Other  Do you feel safe in your home? ☐ Yes ☐ No                | ☐ Move of household                           |  |
| Do you have an Advance Directive, Living Will, or Durable ☐ Yes (Please bring to office so we may make a copy) | · · · · · · · · · · · · · · · · · · ·         |  |
|  | port groups, counseling, nutrition, etc?)     |  |
| Your signature:  |   |  |
| If completed by someone other than the patient:  |   |  |
|  |   |  |
| Name:Relations   | ship:   |  |
| Physician Signature:   | Date:   |  |