Eastern Connecticut Hematology and Oncology, 330 Washington Street #220, Norwich, CT 06360

Patient name_____ Date of Birth:_____

HEALTH ASSESSMENT

Date: _____

Age: _____ Female: ☐ Male: ☐ Primary Language: _____

Reason for coming to office: _____

Name of primary care physician: _____

Names of your other physicians: _____

Home telephone: _____ Work telephone: _____ Cell phone: _____

PRESCRIPTION MEDICATIONS (if not bringing a list with you)

Name of drug	Dose (in mg)	# of times per day

(Please continue on the back of sheet as needed)

Please list any over-the-counter medications/vitamins you take: _____

Please list any herbal medications, food supplements, teas: _____

Do you use any complementary treatments: ☐ Acupuncture ☐ Chiropractic ☐ Herbs/Naturopathy ☐ Meditation ☐ Massage ☐ Other _____

Do you have any allergies to medications ☐ Yes ☐ No

If yes, please list: _____

Do have an allergy to Latex (Band-Aids, rubber gloves, balloons, condoms) ☐ Yes ☐ No

If yes, explain _____

Other allergies: _____

What drug store do you use? _____ Telephone _____

Do you have a prescription plan to assist with the cost of medications? ☐ Yes ☐ No

Patient name_____ Date of Birth:_____

Please choose which best describes your current state: (ECOG Performance Status Scale)

☐ 0- Fully active. Able to carry on all pre-disease activities without restrictions.

☐1 – Restricted in physically strenuous activity but ambulatory and able to perform light work.

☐ 2 – Ambulatory and capable of all self-care but unable to work. Up and about >50% of waking hours.

☐ 3 – Capable of only limited self-care. Confined to bed or chair more than 50% of waking hours.

☐4 – Completely disabled. Cannot perform any self-care. Confined to bed or chair.

MEDICAL HISTORY

How do you rank your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any surgeries you have had in the past: (use additional paper if necessary)

Approx Date	Type of surgery	Where

Please list any chronic conditions for which you see a physician: (use additional paper if necessary)

Condition:	Physician:

Do you have a collagen vascular disease (rheumatoid arthritis, scleroderma, lupus)? ☐ Yes ☐ No

Have you ever had radiation treatment? ☐ Yes ☐ No

Where?_____ When?_____

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 Hispanic origin ☐Jewish Heritage ☐ Other _____

Religion : _____

Marital status:

☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widow

Who do you live with?

Name: _____ Relationship: _____ Cell Phone: _____

Name: _____ Relationship: _____ Cell Phone: _____

Housing: ☐ Single Level ☐ Multi-level ☐ Assisted Living ☐ Nursing Home

Patient name_____ Date of Birth:_____

If assisted living program or nursing home, please name: _____ Phone: _____

On whom do you rely for support 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 you do/ did you do?_____

Are you able to: Shop for self ☐ Yes ☐ No Cook for self ☐ Yes ☐ No Wash self ☐ Yes ☐ No

Transportation: ☐ Wheelchair ☐ Cane ☐ Walker ☐ Crutches ☐ Artificial Limb

☐ Drive Self ☐ Family Assistance ☐ Wheelchair Services ☐ Ambulance ☐ Volunteer Driver

Name of driver/service: _____Phone:_____

Check if you use of any of the following services:

☐ VNA ☐ Private agency homecare ☐ Hospice ☐ Social work ☐ Physical Therapy ☐ Speech Therapy

Check if you receive any of the following benefits?

☐ Disability ☐ Medicaid ☐ State assistance ☐ Unemployment benefits

Tobacco use: Cigarettes - ☐ Never used ☐ Current smoker ☐ Previous smoker

Age started smoking _____ # of packs per day _____ Age quit smoking _____

Chewing Tobacco - ☐ Never used ☐ Current use ☐ Previous use

Age started _____ Age quit _____

Do you currently drink alcohol? ☐ Yes How much: _____ ☐ No

Did you drink alcohol in the past? ☐ Yes How much: _____ ☐ No

Do you drink beverages containing caffeine? ☐ Yes How much: _____☐ No

REVIEW OF SYSTEMS

GENERAL

Please check if you have any of the following: ☐ Fatigue ☐ Fever ☐ Sweats

EYE, EAR, NOSE, THROAT, MOUTH ☐ NO PROBLEM

Any problems with: ☐ Vision ☐ Hearing ☐ Sinuses ☐ Dry mouth ☐ Teeth/Gums

☐ Altered taste or smell ☐ Mouth sores ☐ Swallowing ☐ Sore Throat

If yes, describe: _____

Patient name_____ Date of Birth:_____

Do you have dentures: ☐ Yes ☐ No ☐ Upper ☐ Lower ☐ Partial

Do your dentures fit properly? ☐ Yes ☐ No Explain _____

HEART ☐ NO PROBLEM

Any problems with:

☐ Blood pressure ☐ Chest pain ☐ Fainting ☐ Irregular heartbeat ☐ Palpitations

☐ Swollen ankles ☐ Other _____

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

LUNG ☐ NO PROBLEM

Any problems with:

☐ Asthma ☐ Cough ☐ Other _____

☐ Shortness of breath -- ☐ At rest ☐ Walking ☐ Climbing stairs _____ # of flights

Do you use oxygen? ☐ Yes Hours per day _____ Liters per minute _____ ☐ No

GASTRO-INTESTINAL ☐ NO PROBLEM

Any problems with:

☐ Constipation ☐ Diarrhea ☐ Change in bowel pattern

☐ Blood in stools ☐ Abdominal discomfort ☐ Nausea ☐ Vomiting

☐ Change in appetite ☐ Indigestion ☐ Reflux ☐ Other _____

Do you have a colostomy? ☐ Yes ☐ No

Date of last bowel movement_____ Average frequency _____

NUTRITION ASSESSMENT ☐ NO 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: _____

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

If yes, describe _____

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 long _____months/years when stopped: _____

Have you ever used hormone-replacement therapy: ☐Yes ☐No
If yes, how long _____months/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 ☐ NO PROBLEM

Do you exercise on a regular basis: ☐ Yes ☐ No
How frequently: _____ What type: _____

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

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

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: _____

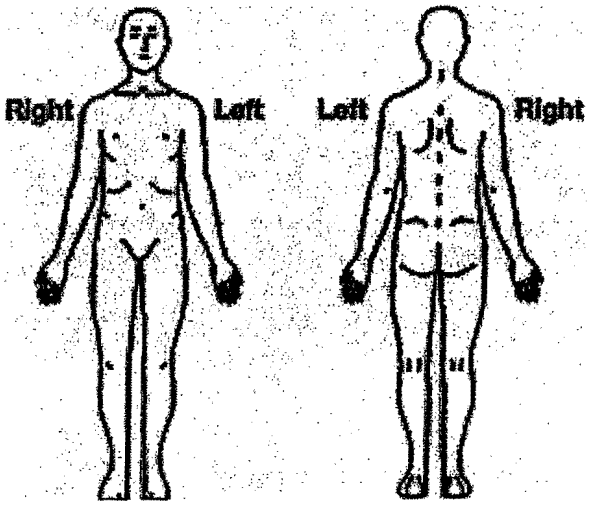
Date of last colonoscopy: _____

Bone Density _____

Dermatology skin exam _____

COMFORT/PAIN

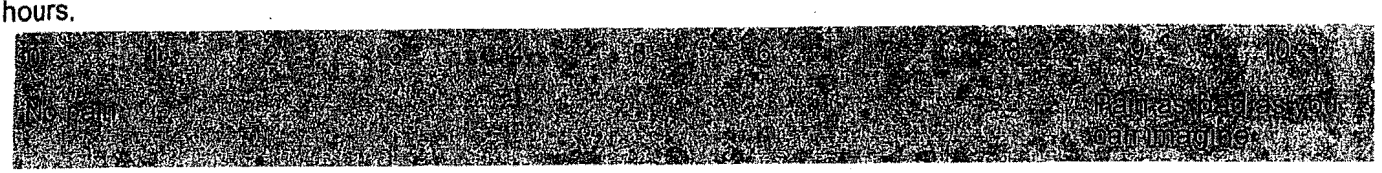
Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today? ☐ Yes ☐ No - please skip to Page 9



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

Patient name_____ Date of Birth:_____

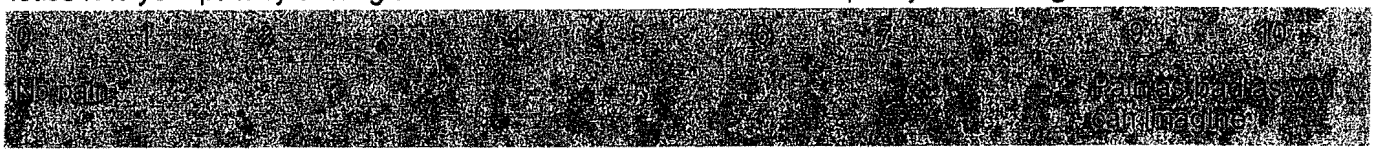
Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.



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 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

Do you have any religious or cultural practices we should be aware of during your treatment?

☐ 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

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 services 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: _____

Eastern Connecticut Hematology and Oncology, 330 Washington Street #220, Norwich, CT 06360

Patient name_____ Date of Birth:_____

HEALTH ASSESSMENT

Date: _____

Age: _____ Female: ☐ Male: ☐ Primary Language: _____

Reason for coming to office: _____

Name of primary care physician: _____

Names of your other physicians: _____

Home telephone: _____ Work telephone: _____ Cell phone: _____

PRESCRIPTION MEDICATIONS (if not bringing a list with you)

Name of drug	Dose (in mg)	# of times per day

(Please continue on the back of sheet as needed)

Please list any over-the-counter medications/vitamins you take: _____

Please list any herbal medications, food supplements, teas: _____

Do you use any complementary treatments: ☐ Acupuncture ☐ Chiropractic ☐ Herbs/Naturopathy

☐ Meditation ☐ Massage ☐ Other _____

Do you have any allergies to medications ☐ Yes ☐ No

If yes, please list: _____

Do have an allergy to Latex (Band-Aids, rubber gloves, balloons, condoms) ☐ Yes ☐ No

If yes, explain _____

Other allergies: _____

What drug store do you use? _____ Telephone _____

Do you have a prescription plan to assist with the cost of medications? ☐ Yes ☐ No

Patient name_____ Date of Birth:_____

Please choose which best describes your current state: (ECOG Performance Status Scale)

☐ 0- Fully active. Able to carry on all pre-disease activities without restrictions.

☐1 – Restricted in physically strenuous activity but ambulatory and able to perform light work.

☐ 2 – Ambulatory and capable of all self-care but unable to work. Up and about >50% of waking hours.

☐ 3 – Capable of only limited self-care. Confined to bed or chair more than 50% of waking hours.

☐4 – Completely disabled. Cannot perform any self-care. Confined to bed or chair.

MEDICAL HISTORY

How do you rank your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any surgeries you have had in the past: (use additional paper if necessary)

Approx Date	Type of surgery	Where

Please list any chronic conditions for which you see a physician: (use additional paper if necessary)

Condition:	Physician:

Do you have a collagen vascular disease (rheumatoid arthritis, scleroderma, lupus)? ☐ Yes ☐ No

Have you ever had radiation treatment? ☐ Yes ☐ No

Where?_____ When?_____

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 Hispanic origin ☐Jewish Heritage ☐ Other _____

Religion : _____

Marital status:

☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widow

Who do you live with?

Name: _____ Relationship: _____ Cell Phone: _____

Name: _____ Relationship: _____ Cell Phone: _____

Housing: ☐ Single Level ☐ Multi-level ☐ Assisted Living ☐ Nursing Home

Patient name_____ Date of Birth:_____

If assisted living program or nursing home, please name: _____ Phone: _____

On whom do you rely for support 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 you do/ did you do?_____

Are you able to: Shop for self ☐ Yes ☐ No Cook for self ☐ Yes ☐ No Wash self ☐ Yes ☐ No

Transportation: ☐ Wheelchair ☐ Cane ☐ Walker ☐ Crutches ☐ Artificial Limb

☐ Drive Self ☐ Family Assistance ☐ Wheelchair Services ☐ Ambulance ☐ Volunteer Driver

Name of driver/service: _____Phone:_____

Check if you use of any of the following services:

☐ VNA ☐ Private agency homecare ☐ Hospice ☐ Social work ☐ Physical Therapy ☐ Speech Therapy

Check if you receive any of the following benefits?

☐ Disability ☐ Medicaid ☐ State assistance ☐ Unemployment benefits

Tobacco use: Cigarettes - ☐ Never used ☐ Current smoker ☐ Previous smoker

Age started smoking _____ # of packs per day _____ Age quit smoking _____

Chewing Tobacco - ☐ Never used ☐ Current use ☐ Previous use

Age started _____ Age quit _____

Do you currently drink alcohol? ☐ Yes How much: _____ ☐ No

Did you drink alcohol in the past? ☐ Yes How much: _____ ☐ No

Do you drink beverages containing caffeine? ☐ Yes How much: _____ ☐ No

REVIEW OF SYSTEMS

GENERAL

Please check if you have any of the following: ☐ Fatigue ☐ Fever ☐ Sweats

EYE, EAR, NOSE, THROAT, MOUTH ☐ NO PROBLEM

Any problems with: ☐ Vision ☐ Hearing ☐ Sinuses ☐ Dry mouth ☐ Teeth/Gums

☐ Altered taste or smell ☐ Mouth sores ☐ Swallowing ☐ Sore Throat

If yes, describe: _____

Patient name_____ Date of Birth:_____

Do you have dentures: ☐ Yes ☐ No ☐ Upper ☐ Lower ☐ Partial

Do your dentures fit properly? ☐ Yes ☐ No Explain _____

HEART ☐ NO PROBLEM

Any problems with:

☐ Blood pressure ☐ Chest pain ☐ Fainting ☐ Irregular heartbeat ☐ Palpitations

☐ Swollen ankles ☐ Other _____

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

LUNG ☐ NO PROBLEM

Any problems with:

☐ Asthma ☐ Cough ☐ Other _____

☐ Shortness of breath -- ☐ At rest ☐ Walking ☐ Climbing stairs _____ # of flights

Do you use oxygen? ☐ Yes Hours per day _____ Liters per minute _____ ☐ No

GASTRO-INTESTINAL ☐ NO PROBLEM

Any problems with:

☐ Constipation ☐ Diarrhea ☐ Change in bowel pattern

☐ Blood in stools ☐ Abdominal discomfort ☐ Nausea ☐ Vomiting

☐ Change in appetite ☐ Indigestion ☐ Reflux ☐ Other _____

Do you have a colostomy? ☐ Yes ☐ No

Date of last bowel movement_____ Average frequency _____

NUTRITION ASSESSMENT ☐ NO 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: _____

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

If yes, describe _____

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 long _____months/years when stopped: _____

Have you ever used hormone-replacement therapy: ☐Yes ☐No
If yes, how long _____months/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 ☐ NO PROBLEM

Do you exercise on a regular basis: ☐ Yes ☐ No
How frequently: _____ What type: _____

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

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

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: _____

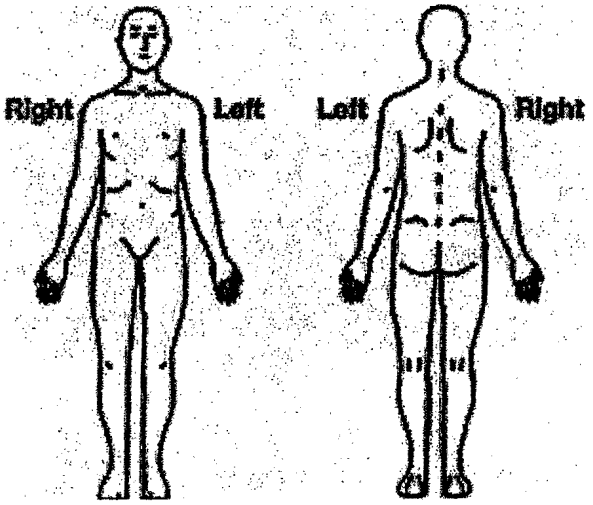
Date of last colonoscopy: _____

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? ☐ Yes ☐ No - please skip to Page 9

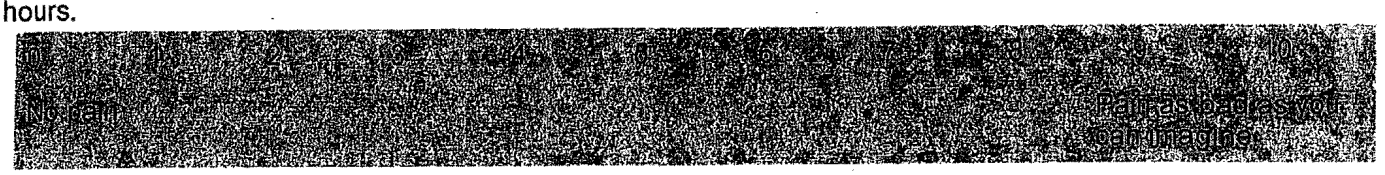


On the diagram, shade in the areas where you feel pain. Put an **X** on the area(s) that hurt(s) the most.

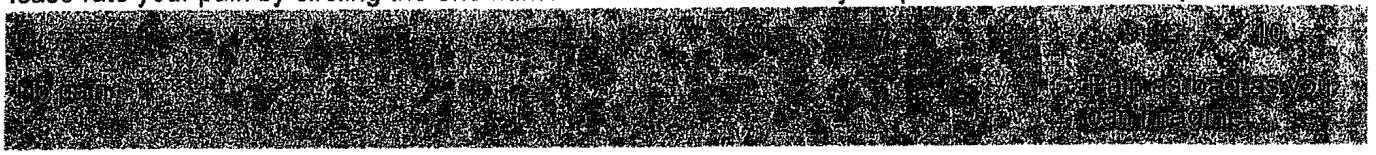
Eastern Connecticut Hematology and Oncology, 330 Washington Street #220, Norwich, CT 06360

Patient name_____ Date of Birth:_____

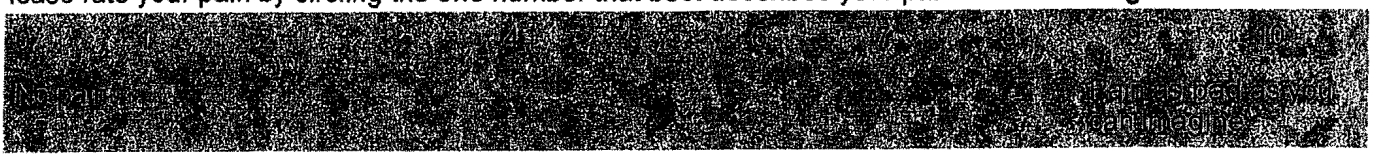
Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.



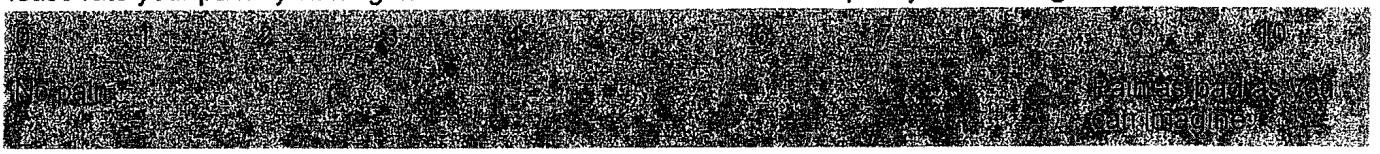
Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.



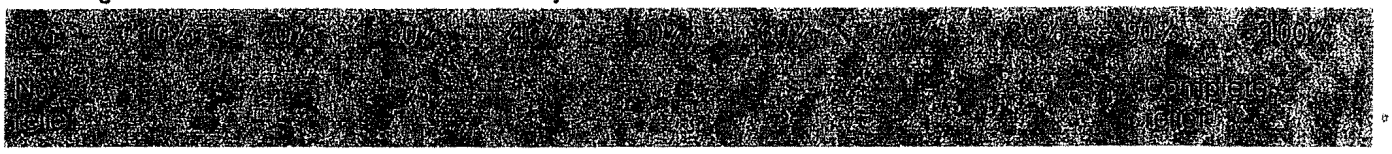
Please rate your pain by circling the one number that best describes your pain on the **average**.



Please rate your pain by circling the one number that 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

Do you have any religious or cultural practices we should be aware of during your treatment?

☐ 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

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 services 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: _____