RUTGERS
Cancer Institute
of New Jersey

Health History

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

Please answer the following questions and bring this form to your first appointment at Rutgers Cancer Institute of New Jersey. This information will help your healthcare team plan your care.

Name: Date:

Email Address: Date of Birth:

Tests and Procedures:

Test:	Date:	Location:	Provider:	Abnormal:	Results/Notes:
Monthly self breast exam					
Last mammogram (female)					
Last PAP smear (female)					
Last PSA test (male)					
Last colonoscopy or sigmoidoscopy					
Last prostate exam (male)					
Last bone density scan					
Last chest x-ray					
Biopsy					
Biopsy					

Immunizations:

Type:	Date:	Comments:

Cancer and Blood Disorder History:

Have you ever been diagnosed with a cancer or blood disorder? *(Circle one)*: **Yes | No**

Diagnosis:	Date:	Doctor:	Chemo	RT	Sur	Alt	Additional Comments:

RUTGERS
Cancer Institute
of New Jersey

Health History

Name: Date of Birth:

Other Diagnosis and Medical Conditions:

Diagnosis:	Date:	Additional Comments:

Past Surgeries and Hospitalizations:

Have you ever been hospitalized or had any surgeries? *(Circle one)*: **Yes | No**

Surgeries • Type of Surgery:	Date:	Hospital / Doctor / Notes:

Hospitalizations • When • Where:	Reason:

Medications:

Are you currently taking any prescriptions, over-the-counter medications, or alternative medications on a regular basis? *(Circle one)*: **Yes | No**

Medication:	Frequency:	Dosage:	Started on:	Stopped on:

Allergies:

Have you ever had an adverse reaction to IV dye used for X-ray studies? *(Circle one)*: **Yes | No**
Do you have any allergies? *(Circle one)*: **Yes | No**

Allergic to:	Reaction:

RUTGERS
Cancer Institute
of New Jersey

Health History

Name: Date of Birth:

Female History:

Menstrual Period History:			
Age at first menstrual period:			
Last menstrual period:			
Reason period stopped:			
Notes:			
Pregnancy History:			
Have you ever been pregnant?		Number of Pregnancies:	
Number of births:		Age at first birth:	Age at last birth:
Notes:			
Breastfed?		Currently pregnant:	
Could be pregnant:		Trying to get pregnant:	

History of Hormone Use:	
Have you ever taken birth control hormones (ie: pill, patch, injection)?	
Have you ever taken medication to increase your chance of pregnancy?	
Have you ever had Hormone Replacement Therapy (HRT)?	
Have you ever had anti-hormonal therapy?	

Family Health History:

Are you adopted?	Are you of Ashkenazi Jewish descent?
Twin?	Are you of Sephardic Jewish descent?

Immediate and Extended Family (include aunts, uncles, and grandparents):

Relation:	Name:	Status:	Cancer:	Other Illness:

Do you have any biological children? *(Circle one)*: **Yes | No**

Gender:	Name:	Status:	Cancer:	Other Illness:

RUTGERS
Cancer Institute
of New Jersey

Health History

Name: Date of Birth:

Social and Lifestyle:

Tobacco Use:	Ever Used?	Frequency:	Number of Years:	Stopped?	Interested in Stopping?
Cigarettes					
Cigars					
Pipe					
Chewing Tobacco:					

Other Substance Use:	Ever Used?	What Kind?	Frequency:	Interested in Stopping?
Alcohol				
Caffeinated Beverages				
Recreational Drugs				

Emotional Assistance:

Have you ever seen a professional for help with emotional problems? Explain:

Professional Needs:

At this time, do you feel you need help with any of the following areas?

Coping	Financial Assistance	Nutrition
Home Assistance	Insurance	Transportation
Other		

Health Maintenance:

Date of last family doctor visit:			Date of last dental exam:	
Recent dermatologist visit (circle one): Yes | No		Date:	Reason:	

Exercise Frequency and Mobility:

Diet (circle one):	Diabetic	Liquid	Regular	Vegetarian
Mobility device used (circle one):	Cane	Walker	Wheelchair	None

Describe any assistance needed for daily activities:
Do you have transportation to your office appointments?
Do you have family/friends to assist with your needs?
Are you in an assisted-living environment? If so, which one?
Are you currently under hospice care? If so, which one?
Religious beliefs you would like us to be aware of:

RUTGERS
Cancer Institute
of New Jersey

Health History

Name: Date of Birth:

Review of Symptoms:

General	Yes	No		Yes	No		Yes	No
Fatigue			Fever / chills			Night Sweats		
Weight gain			Loss of appetite			Unexplained weight loss		
Special diet			Change in diet			Diabetes: diet control		
Diabetes: oral medications			Diabetes: Insulin dependent			Other related issues		
Pain			Leg pain, walking			Leg pain, resting		
Lungs and Breathing	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Coughing up blood			Short of breath, resting			Short of breath, walking		
Wheezing			Other related issues			Cough		
Heart, Blood, Circulation	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Chest Pain			Palpitations			Ankle/foot swelling		
Other related issues			Bleeding problems			Bruise easily		
Hematology issues			Legs/arms swelling					
Digestive/Gastrointestinal	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Abdominal pain			Constipation			Rectal bleeding		
Diarrhea			Heartburn			Hemorrhoids		
Difficulty swallowing			Vomiting blood			Yellow skin/jaundice		
Other related issues			Nausea/Vomiting			Black stools		
Urinary	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Dark urine			Blood in urine			Burning		
Dribbling			High frequency			Urgency		
Losss of control			Pain with urination			Other related issues		
Neurological	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Headache			Numbness/tingling			Fainting spells		
Dizziness			Memory loss			Seizures		
Coordination problems			Trouble talking			Other related issues		
Musculoskeletal	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Muscle weakness			Swollen joints			Joint/back pain		
Bone pain			Muscle pain			Muscle cramps		
Stiffness			Other related issues					
Eyes	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Blurred vision			Red eyes			Double vision		
Eye pain			Other related issues			Visual changes		
Ears	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Ear drainage			Ringing in ears			Ear Pain		
Other related issues								

RUTGERS
Cancer Institute
of New Jersey

Health History

Name: Date of Birth:

Review of Symptoms:

Mouth, Nose, Throat	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Sinus pain			Nose bleeds			Sore throat		
Hoarseness			Mouth sores			Other related issues		
Runny/stuffy nose								
Lymphatics	**Yes**	**No**		**Yes**	**No**			
Swollen glands in neck			Groin/armpit swelling					
Endocrine	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Increased thirst			Heat or cold intolerant			Hot flashes		
Nervousness			Other related issues					
Skin	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Open sores			Change in moles/freckles			Abnormal coloration		
Rashes/hives			Dry skin			Hair loss		
Other related issues			Prone to sunburn					
Breast / Chest	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Breast changes			Lumps			Nipple discharge		
Breast pain			Other related issues					
Psychological	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Worried/anxious			Difficulty sleeping			Excessive sleeping		
Mood swings			Panic attacks			Psychiatric problems		
Mood medications/supplements			Other related issues			Confused/forgetful		
Depressed			Agitated			Hyperactivity		
Claustrophobia								
Men	**Yes**	**No**		**Yes**	**No**			
Impotence			Trouble passing urine					
Women	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Vaginal dryness			Vaginal discharge			Abnormal vaginal bleeding		
Irregular menses			Painful intercourse					
Physical Functioning	**Yes**	**No**						
Physical functioning								

Preferred Pharmacy:	**Living Will & Power of Attorney:**
Name:	Do you have a living will *(Circle one)*: **Yes** | **No**
Address:	Medical Power of Attorney to make decisions on your behalf:
	Name: Relation:
Phone:	Phone:

Name: Date of Birth:

List of current physicians:

Who are your current physicians?	
Name:	
Address:	
Phone: ( )	Fax: ( )
Name:	
Address:	
Phone: ( )	Fax: ( )
Name:	
Address:	
Phone: ( )	Fax: ( )
Name:	
Address:	
Phone: ( )	Fax: ( )
Name:	
Address:	
Phone: ( )	Fax: ( )
Name:	
Address:	
Phone: ( )	Fax: ( )
Name:	
Address:	
Phone: ( )	Fax: ( )
Name:	
Address:	
Phone: ( )	Fax: ( )
Name:	
Address:	
Phone: ( )	Fax: ( )
Name:	
Address:	
Phone: ( )	Fax: ( )
Name:	
Address:	
Phone: ( )	Fax: ( )