Maui
PACIFIC
CANCER INSTITUTE
(808) 249-1600 | Fax (808) 249-1651 | 227 Mahalani Street, Wailuku, HI 96793-2526

Name: _____ Appointment date: _____

Date of birth: _____ Age: _____

MEDICAL INFORMATION

What type of cancer have you been diagnosed with and where is it located?

_____

_____

Please list the symptoms that led to your cancer diagnosis:

_____

_____

What symptoms are you currently experiencing?

_____

_____

Please list any cancer-related procedures you have had since your cancer diagnosis:

Date	Procedure/Illness	Physician/Surgeon	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any current or past medical illnesses you have:

Illness	Physician	Illness	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any surgeries you have had in the past:

Date	Procedure	Surgeon	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Do you have a pacemaker? _____ If so, who is your cardiologist? _____

Have you ever been diagnosed with a connective tissue disease such as systemic lupus erythematosus ("Lupus"), systemic sclerosis ("scleroderma"), or mixed connective tissue disease? _____
If so, please specify and note when you were diagnosed: _____
_____

Have you ever had any previous chemotherapy and/or radiation therapy treatments? _____
If so, please specify below:

Date	Hospital or Clinic	Description
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

If there is cancer in your family history, please list here:

Description	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

If there are any other diseases/conditions in your family history, please list here:

Description	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

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SOCIAL HISTORY

Please list any habits:

	Type	Frequency	Number of years	If quit, when?
Tobacco:	_____	_____	_____	_____
Alcohol:	_____	_____	_____	_____
Other :	_____	_____	_____	_____

Are you on any special diet? If so, please specify: _____

Occupation: _____ Marital status: _____

Who lives at home with you? _____ Have you received the flu shot? Yes No When?_____

Women: Number of pregnancies _____ Number of live births: _____

MEDICATIONS

Please list all medications, vitamins and herbal supplements that you are taking:

Description	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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ALLERGIES

Do you have any allergies to any medications/foods/other substances?

If none, please check here: _____ If yes, please list your allergy and your reaction:

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

PHYSICIAN INFORMATION

Referring physician: _____

Primary care physician: _____

Other physicians: _____

PHYSICAL EXAMINATION (to be filled out by nurse)

Height: _____ Weight: _____ Temp: _____ RR: _____ HR: _____ BP: _____

Pain: _____ Location: _____

ECOG score: _____