PRINT SAVE AS EMAIL RESET

Fred Hutch Cancer Center

# Self-Reporting Health History

*Please complete this questionnaire*

*Date:* _____

## DEMOGRAPHIC INFORMATION

Full Legal Name: | Name you prefer us to call you: | Pronouns: | Date of Birth:

Permanent Address:

Home Phone: | Work Phone:

Local Address:

Local Phone: | Cell Phone: | Pager:

Emergency Contact Person (different phone number from above)

Name: | Phone #:

Do you need an interpreter? ☐ Y ☐ N If yes, what language? _____

## PAST CANCER HISTORY

**Have you or any family member had cancer? ☐ Y ☐ N (If yes, please list below)**

| Cancer Type | Relationship (self/mother/father's side) | Age at diagnosis | Present age or age at death |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Provider Comments

## HAVE YOU PREVIOUSLY HAD radiation therapy ☐ Y ☐ N chemotherapy ☐ Y ☐ N

If yes, when/where?

## PLEASE LIST ANY RECENT TESTS/SURGERIES/MEDICAL VISITS

## DOCTORS YOU CURRENTLY SEE

| NAME(S)/CLINIC | CITY/STATE | REASON |
|---|---|---|
| | | |
| | | |
| | | |

## ARE YOU CURRENTLY USING ANY COMPLIMENTARY METHODS OF TREATMENT? ☐ Y ☐ N

TEAM

NAME [ M ]

PLACE EPIC LABEL HERE

PT NO [ F ]

DOB

Fred Hutchinson Cancer Center is an independent organization that serves as UW Medicine's cancer program.

UW Medicine

*SINT002*

Fred Hutch Cancer Center

## Self-Reporting Health History

### HAVE YOU HAD OR DO YOU HAVE: *(Check all that apply)*

| | Now | Past |
|---|---|---|
| ☐ High/low blood pressure | ☐ | ☐ |
| ☐ Chest pain | ☐ | ☐ |
| ☐ Angina | ☐ | ☐ |
| ☐ Heart attacks | ☐ | ☐ |
| ☐ Congestive heart failure | ☐ | ☐ |
| ☐ Pacemaker | ☐ | ☐ |
| ☐ Defibrillator | ☐ | ☐ |
| ☐ Palpitations | ☐ | ☐ |
| ☐ Irregular heart beat | ☐ | ☐ |

| | Now | Past |
|---|---|---|
| ☐ Murmur | ☐ | ☐ |
| ☐ Rheumatic fever | ☐ | ☐ |
| ☐ EKG in past six months? | ☐ | ☐ |
| If yes, where? _____ | | |
| ☐ Swelling | ☐ | ☐ |
| ☐ Bleeding | ☐ | ☐ |
| ☐ Bruising | ☐ | ☐ |
| ☐ Leg Pain | ☐ | ☐ |

| | Now | Past |
|---|---|---|
| ☐ Current bronchitis | ☐ | ☐ |
| ☐ Current chronic cough | ☐ | ☐ |
| ☐ Current cold / flu | ☐ | ☐ |
| ☐ Pneumonia | ☐ | ☐ |
| ☐ Tuberculosis | ☐ | ☐ |
| ☐ Asthma | ☐ | ☐ |
| ☐ Hay fever | ☐ | ☐ |

| | Now | Past |
|---|---|---|
| ☐ Hoarseness | ☐ | ☐ |
| ☐ Sore throat | ☐ | ☐ |
| ☐ Emphysema | ☐ | ☐ |
| ☐ Shortness of breath | ☐ | ☐ |
| ☐ Wheezing | ☐ | ☐ |
| ☐ Any other lung problems? | ☐ | ☐ |
| _____ | | |

| | Now | Past |
|---|---|---|
| ☐ Herpes | ☐ | ☐ |
| ☐ Mononucleosis | ☐ | ☐ |
| ☐ Recent exposure to chicken pox | ☐ | ☐ |
| ☐ Jaundice | ☐ | ☐ |
| ☐ Hepatitis | ☐ | ☐ |
| ☐ Liver problem | ☐ | ☐ |

| | Now | Past |
|---|---|---|
| ☐ Kidney | ☐ | ☐ |
| ☐ Bladder problems | ☐ | ☐ |
| ☐ Diabetes | ☐ | ☐ |
| ☐ High or low blood sugar | ☐ | ☐ |
| ☐ Thyroid problems | ☐ | ☐ |

| | Now | Past |
|---|---|---|
| ☐ Vision problems | ☐ | ☐ |
| ☐ Glasses | ☐ | ☐ |
| ☐ Contact Lenses | ☐ | ☐ |
| ☐ Speech Problems | ☐ | ☐ |
| ☐ Hearing difficulties | ☐ | ☐ |
| ☐ Hearing aid | ☐ | ☐ |
| ☐ Changes in sense of smell | ☐ | ☐ |

| | Now | Past |
|---|---|---|
| ☐ Headaches | ☐ | ☐ |
| ☐ Neck | ☐ | ☐ |
| ☐ Back pain or injury | ☐ | ☐ |
| ☐ Current Cuts | ☐ | ☐ |
| ☐ Bruises | ☐ | ☐ |
| ☐ Burns | ☐ | ☐ |
| ☐ Rashes | ☐ | ☐ |

| | Now | Past |
|---|---|---|
| ☐ Seizures | ☐ | ☐ |
| ☐ Stroke | ☐ | ☐ |
| ☐ Polio | ☐ | ☐ |
| ☐ Paralysis | ☐ | ☐ |
| ☐ Meningitis | ☐ | ☐ |
| ☐ Arthritis | ☐ | ☐ |
| ☐ Numbness | ☐ | ☐ |
| ☐ Tingling | ☐ | ☐ |
| ☐ Dizziness | ☐ | ☐ |

Do you presently smoke? ☐ Y ☐ N # packs per day? _____ x How many years? _____
Have you ever smoked? ☐ Y ☐ N # packs per day? _____ x How many years? _____
Year quit smoking: _____

Do you drink alcohol (beer/wine/liquor)? ☐ Y ☐ N
If yes, how often and how much do you consume? _____
Has alcohol or other recreational drugs ever caused problems for you? ☐ Y ☐ N

### NUTRITIONAL/METABOLIC: *(Check all that apply)*

Are you experiencing any of the following?

| | | |
|---|---|---|
| ☐ Loss of appetite | ☐ Now | ☐ Past |
| ☐ Nausea | ☐ Now | ☐ Past |
| ☐ Vomiting | ☐ Now | ☐ Past |
| ☐ Difficulty chewing | ☐ Now | ☐ Past |
| ☐ Difficulty swallowing | ☐ Now | ☐ Past |
| ☐ Mouth sores | ☐ Now | ☐ Past |

Do you have dentures? ☐ Y ☐ N
if yes, ☐ partial ☐ lower ☐ upper

Weight change in the last 3 months ☐ Y ☐ N
if yes, weight gain _____ lbs; or
weight loss _____ lbs
Was this intentional? ☐ Y ☐ N

**Provider Comments**

TEAM

NAME

PT NO

DOB

PLACE EPIC LABEL HERE

[ M ]

[ F ]

Fred Hutchinson Cancer Center is an independent organization that serves as UW Medicine's cancer program.

UW Medicine

*SINT002*

Fred Hutch Cancer Center

**Self-Reporting Health History**

## PAIN

Do you currently have pain? ☐ Y ☐ N (If no, go to the next section.)
If yes, describe the location(s) of your pain: _____

When do you have pain? _____

What is the pattern of your pain? ☐ constant ☐ comes / goes
How do you rate your pain on a scale of 0 to 10? _____ (0 = No pain, 10 = Worst pain)
Check the word(s) which describe your pain:
☐ piercing ☐ dull ache ☐ shooting ☐ burning ☐ cramping ☐ stinging
What are you doing to decrease your pain? _____

## ACTIVITY/REST

Please rate your activity level by checking one of the numbers

☐ 0 Fully active; able to carry on all pre-disease activities without restriction.
☐ 1 Restricted in physically strenuous activities, but ambulatory and able to carry out work of a light or sedentary nature (light office or housework).
☐ 2 Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 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 carry on any self-care. Totally confined to bed or chair.

Do you have regular physical activity or exercise? ☐ Y ☐ N
If yes, what do you do? _____

Has your sleep pattern changed in the past 3 months? ☐ Y ☐ N

## ELIMINATION: *(Check all that apply)*

**Bladder:**

| | | |
|---|---|---|
| ☐ Dribbling | ☐ Now | ☐ Past |
| ☐ Burning | ☐ Now | ☐ Past |
| ☐ No control | ☐ Now | ☐ Past |
| ☐ Pain | ☐ Now | ☐ Past |
| ☐ Up at night to go | ☐ Now | ☐ Past |
| ☐ Trouble starting to go | ☐ Now | ☐ Past |
| ☐ Blood in urine | ☐ Now | ☐ Past |
| ☐ Frequent urination | ☐ Now | ☐ Past |

☐ Other: _____

**Bowels:**

| | | |
|---|---|---|
| ☐ Diarrhea | ☐ Now | ☐ Past |
| ☐ Constipation | ☐ Now | ☐ Past |
| ☐ Blood in stool | ☐ Now | ☐ Past |
| ☐ Pain | ☐ Now | ☐ Past |
| ☐ Hemorrhoids | ☐ Now | ☐ Past |
| ☐ Up at night to go | ☐ Now | ☐ Past |

☐ Other: _____

## REPRODUCTION

Are you planning to have (more) children? ☐ Y ☐ N
Do you use birth control? – circle appropriate type
(tubal ligation, vasectomy, pill, IUD, condoms, diaphragm) Diaphragm

**Provider Comments**

TEAM
NAME [ M ]
PLACE EPIC LABEL HERE
PT NO [ F ]
DOB

Fred Hutchinson Cancer Center is an independent organization that serves as UW Medicine's cancer program.

UW Medicine

*SINT002*

Fred Hutch Cancer Center

## Self-Reporting Health History

### REPRODUCTIVE HISTORY

Are you pregnant or is there a possibility that you could be pregnant? ☐ Y ☐ N
Age of first menstrual period: _____
Do you have menstrual periods? ☐ Y ☐ N
If no, when did your periods stop? _____
If stopped less than 1 year ago, are you/your partner using birth control? ☐ Y ☐ N
Have you ever taken hormones? ☐ Y ☐ N
If yes, what and for how long? _____
circle type (Birth control pill/patch, Estrogen, Premarin, Provera, Progesterone)
Have you stopped hormone replacement? ☐ Y ☐ N
If yes, when? _____
Have you had any pregnancies? ☐ Y ☐ N
If yes, how many? _____ ; how many children? _____
Age at first pregnancy: _____

**Provider Comments**

### COPING/STRESS

What method do you learn from best?
☐ Reading ☐ Listening ☐ Written ☐ Demonstration
☐ Other: _____
Do you feel you have increased/additional stress in your life? ☐ Y ☐ N
If yes, please describe:

_____

_____

In the last year, have there been any major events in your life: ☐ Y ☐ N
If yes, please describe:

_____

_____

Who, or what, is most helpful when you are under stress?

_____

_____

Are there any issues regarding your sexuality that you would like to discuss? ☐ Y ☐ N
Is there anything else you want us to know?

_____

_____

Would you be interested in a phone follow-up call from an Fred Hutchinson Cancer Center clinical social worker to discuss methods for reducing distress caused by anxiety and/or depression? ☐ Y ☐ N

### Religious/cultural beliefs we should be aware of during your treatment? ☐ Y ☐ N

If you wish, please explain:

Patient's Signature: _____

*Name if someone other than patient:* _____

*Relationship:* _____ Date: _____

| PHYSICIAN SIGNATURE: | ORDERING/ATTENDING PRINTED NAME: | NPI CODE: | DATE: | TIME: | ICD-9 CD: |
|---|---|---|---|---|---|
| REQUIRED | REQUIRED | REQUIRED | REQUIRED | REQUIRED | REQUIRED |

TEAM
NAME [ M ]
PLACE EPIC LABEL HERE
PT NO [ F ]
DOB

Fred Hutchinson Cancer Center is an independent organization that serves as UW Medicine's cancer program.

UW Medicine

*SINT002*

INT002 (09/22)