Sutter Health

PATIENT LABEL

COMPREHENSIVE CANCER CENTER
INTEGRATIVE MEDICINE
SELF-REPORTING HEALTH HISTORY - INITIAL VISIT

INTEGRATIVE MEDICINE

DATE:

SELF-REPORTING HEALTH HISTORY - INITIAL VISIT

NOTES

DEMOGRAPHIC INFORMATION Please complete this questionnaire and return it to the nurse.

NAME: _____ **AGE:** _____

PHONE (DAY): _____ **APPOINTMENT DATE:** _____

WHO REFERRED YOU TO THIS SERVICE?

NAME: _____ **PHONE NUMBER:** _____

PLEASE LIST ALL OF YOUR CURRENT PHYSICIANS:

	Referring Physician ❑ Seen for current problem	Other Physician ❑ Seen for current problem	Other Physician ❑ Seen for current problem
Name			
Telephone:			

PLEASE SUMMARIZE YOUR CONCERNS (Please rank them by priority; most important to least important)

CONCERN	WHEN IT STARTED	HOW OFTEN DOES IT OCCUR?	HOW SEVERE IS IT? (Mild, Moderate, Severe)
Example: Back Pain	November 2001	Everyday-7X/week	Severe
1			
2			
3			
4			

WHAT ARE YOUR GOALS FOR THIS VISIT/TREATMENT?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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CANCER DIAGNOSIS AND TREATMENT HISTORY

NOTES

Cancer diagnosis ❑ Yes ❑ No
Specify: ❑ Breast ❑ Colon ❑ Lung ❑ Ovary ❑ Liver ❑ Bone
Past Radiation History ❑ Yes ❑ No Past Chemotherapy History ❑ Yes ❑ No

PAST MEDICAL HISTORY (Please check none or indicate all that apply)

❑ Chronic Fatigue Syndrome	❑ High Blood Pressure	❑ Epilepsy/Seizure
❑ Fibromyalgia	❑ Cirrhosis	❑ Depression
❑ Cataracts	❑ Ulcers	❑ Anxiety
❑ Glaucoma	❑ Ulcerative Colitis	❑ Leukemia
❑ Sleep apnea	❑ Reflux/GERD	❑ Immune Disorders
❑ Tuberculosis	❑ Crohn's Disease	❑ Anemia
❑ Heart Attack	❑ Irritable Bowel Syndrome	❑ Blood Clots
❑ Heart Failure	❑ Hepatitis	❑ Osteoporosis
❑ Heart Murmurs	❑ Kidney Stones	❑ Arthritis
❑ Coronary Artery Disease	❑ Urostomy	❑ Thyroid Problem
❑ Pacemaker	❑ Neuropathy	❑ Diabetes
❑ Atrial Fibrillation	❑ Migraines	
❑ High Cholesterol	❑ Paralysis	

REVIEW OF SYSTEMS (Do you have a history of/have you had frequent or ongoing problems with the following conditions?)

CONSTITUTIONAL:
❑ Fever ❑ Change in Energy ❑ Fatigue ❑ Soaking Sweats (in the last three months)
❑ Excessive thirst ❑ Difficulty sleeping ❑ Frequent Infections
❑ Unexplained weight loss/gain ❑ Hair Loss ❑ None of the Above

SKIN:
❑ Skin Tumors/Moles Removed or Burned ❑ Other_____
❑ Skin Sensitivities/Rashes/Itching ❑ None of the Above

HEAD AND NECK:

❑ Frequent Laryngitis	❑ Sinus Trouble
❑ Change in Vision	❑ Bleeding Gums
❑ Eye Pain	❑ Dry Mouth
❑ Decrease/Loss of Hearing	❑ Sore Mouth/Throat/Tongue
❑ Ear Aches or Drainage	❑ Difficulty Swallowing
❑ Ringing/Buzzing in Ear	❑ Hoarseness/Change in Voice
❑ Change in Taste or Smell	❑ None of the Above
❑ Nose Bleed	

DENTAL HEALTH CARE:
What is the general status of your dental health/care? _____

If you answer yes to any of the questions please tell us the date.			**Date**
1. Have you had dental infections?	❑ YES	❑ NO	_____
2. Root Canals?	❑ YES	❑ NO	_____
3. Fillings?	❑ YES	❑ NO	_____
4. Have you ever had silver mercury fillings?	❑ YES	❑ NO	_____
5. Have you ever had silver mercury fillings removed?	❑ YES	❑ NO	_____
6. Dentures?	❑ YES	❑ NO	_____
Have you had any exposure to toxins (pesticides, heavy metals, hobbies, childhood home)?	❑ YES	❑ NO	_____

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REVIEW OF SYSTEMS Do you have a history of/have you had frequent or ongoing problems with the following conditions? (Continued)

NOTES

BREAST:
- ❑ Last Mammogram Date:_____
- ❑ Lymph Node Removal
- ❑ Swelling/Lymphedema
- ❑ Lumpectomy
- ❑ Mastectomy
- ❑ Lumps in Breast
- ❑ Pain in Breast
- ❑ Nipple Discharge
- ❑ None of the Above

RESPIRATORY:
- ❑ Chronic Cough
- ❑ Chronic or Frequent Infections/Colds
- ❑ Coughed Up Blood
- ❑ Shortness of Breath
- ❑ Wheezing
- ❑ None of the Above

CARDIOVASCULAR:
- ❑ Pain in Legs while Walking
- ❑ Pain/Pressure in Chest/Angina
- ❑ None of the Above

GASTROINTESTINAL:
- ❑ Abdominal Pain
- ❑ Heartburn
- ❑ Nausea/Vomiting
- ❑ Feeling Full/Bloating
- ❑ Gas
- ❑ Black Bowel Movements
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in Stools
- ❑ None of the Above
- ❑ Last Colonoscopy Date: _____

GENITOURINARY:
- ❑ Lump in Testicle ❑ L ❑ R
- ❑ Difficulty in Urination/Slow Start in Stream
- ❑ Urgency
- ❑ Frequent, Painful or Burning Urination
- ❑ Incontinence or Loss of Control
- ❑ Frequent Night Time Urination
- ❑ None of the Above

GYNECOLOGIC:
- ❑ Age of Onset of Menstruation:_____
- ❑ Date of Last Period:_____ ❑ Regular ❑ Irregular
- ❑ Frequency and Duration of Periods: _____
- ❑ Have you ever used birth control (tubal ligation, pill, IUD, condoms, diaphragm)?
  Type: _____ How long:_____ When Stopped: _____
- Present Method of Birth Control _____
- ❑ Last Pap Smear_____ ❑ Vaginal Discharge/Bleeding
- ❑ Are you using any hormones? (include birth control pills) ❑ YES ❑ NO
- ❑ Number of Pregnancies:_____ Age at 1st full term Pregnancy:_____ ❑ Currently Lactating
- ❑ Number of Births (live):_____ ❑ Number of Miscarriages:_____
- ❑ Menopause Age_____ ❑ Hot Flashes

NEUROLOGICAL:
- ❑ Memory Loss
- ❑ Confusion
- ❑ Headaches
- ❑ Balance Change
- ❑ Tremor
- ❑ Numbness/Tingling of Hands/Feet
- ❑ Clumsiness of Hands/Feet
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Weakness: ❑ LA ❑ RA ❑ LL ❑ RL
- ❑ None of the Above

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REVIEW OF SYSTEMS Do you have a history of/have you had frequent or ongoing problems with the following conditions? (Continued)

NOTES

PSYCHOSOCIAL:

- ❑ Nervousness
- ❑ Anxiety
- ❑ Depression
- ❑ None of the Above

HEMATOLOGICAL/LYMPHATIC/IMMUNOLOGIC:

- ❑ Easy Bruising
- ❑ Swollen or Enlarged Glands
- ❑ Anemia
- ❑ None of the Above

MUSCULOSKELETAL:

- ❑ Limited Motion
- ❑ Muscle Pain, Cramps
- ❑ Joint Pain or Stiffness
- ❑ Neck Pain
- ❑ Joint Swelling
- ❑ Lumbar Back Pain
- ❑ None of the Above

SEXUALITY:

1. Are you currently sexually active? ❑ YES ❑ NO
2. Do you have a history of sexually transmitted disease? ❑ YES ❑ NO
3. Do you experience pain with intercourse? ❑ YES ❑ NO
4. Do you have difficulty with erection? ❑ YES ❑ NO
5. Other: _____

PAST HOSPITALIZATIONS AND/OR SURGERIES (OPERATIONS): PLEASE LIST CHRONOLOGICALLY

Year	Problem	Hospital	Doctor

PAST INJURIES: PLEASE LIST CHRONOLOGICALLY

Year	Problem	How Treated	Doctor

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FAMILY ILLNESS HISTORY Have any of your blood relatives, husband, wife or children had:
❑ NONE OF THE BELOW

Disorder	Relation	Disorder	Relation
❑ Anemia		❑ Ulcer	
❑ Bleeding Tendency		❑ Thyroid Disease	
❑ Leukemia		❑ Arthritis	
❑ Kidney Disease		❑ Nervous/Mental Disorder	
❑ Coronary Artery Disease		❑ Tuberculosis	
❑ High Cholesterol		❑ Heart Disease	
❑ Reflux		❑ High Blood Pressure	
❑ High Cholesterol		❑ Asthma/Chronic Bronchitis	
❑ Hepatitis		❑ Other Illness	
❑ Immune Disorder		_____	
❑ Stroke		_____	
❑ Diabetes		_____	

FAMILY CANCER HISTORY Have any of your relatives had a cancer diagnosis?
If yes, please list the site of cancer:

	Mother/Father	Siblings	Aunts/Uncles	Cousins
Cancer				
Cancer				
Cancer				

DO YOU HAVE ANY DRUG ALLERGIES? ❑ YES ❑ NO
If yes, please list: (If more than 3, please discuss with your physician)

Allergy	Type of Reaction

PLEASE BRING IN ALL MEDICINES, HERBS AND SUPPLEMENTS FOR REVIEW.

PLEASE LIST ALL PRESCRIPTION OR OVER THE COUNTER MEDICATIONS YOU ARE TAKING:

Drug Name	Dose	How Often	Reason for taking

PLEASE LIST ALL BOTANICAL HERBS AND SUPPLEMENTS YOU ARE TAKING (INCLUDE VITAMINS, CHINESE HERBS, HOMEOPATHY AND AYURVEDA):

Drug Name	Dose	How Often	Reason for taking

NOTES

PLEASE BRING IN ALL FOR REVIEW.
Please use back if more space is needed.

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LIFESTYLE HISTORY, EDUCATION AND EMPLOYMENT	NOTES

LIFESTYLE HISTORY:

1. Marital Status: ❑ Single ❑ Widowed ❑ Married ❑ Divorced ❑ Significant other ❑ Separated How Long?_____
2. What is your primary language? _____
3. With whom do you live and how old are they? (Include roommates, friends, partner, spouse, children, parents and relatives.)_____
   _____
4. Do you have friends and family available to help you during your illness?
   ❑ YES ❑ NO ❑ Unsure
5. ❑ Non-Smoker ❑ Ex-Smoker ___ packs/day ___ years ___ years stopped ❑ Current Smoker____packs/day ____years
   ❑ Cigarettes ❑ Pipe ❑ Cigars ❑ Chewing Tobacco ❑ Marijuana
6. Alcohol _____ drinks/day_____ years
7. Other Substances_____ For_____ years
8. What interests/hobbies do you have?_____
   _____
9. What physical activity do you participate in?_____
   _____
10. What are your major life stressors?_____
    _____
11. What do you do to relax?_____
    _____

EDUCATION: Highest Grade Completed:_____ Degree:_____

EMPLOYMENT:

1. Are you currently employed? ❑ YES ❑ NO
2. What is/was your occupation?_____

FALL RISK ASSESSMENT

1. Have you ever fallen? ❑ YES ❑ NO Date of last fall: _____
2. Do you use any assistive device: ❑ Walker ❑ Cane ❑ Crutches
3. Do you feel unsteady when you walk? ❑ YES ❑ NO

ABUSE RISK

Because violence is a problem for many people, we are required by law to assess this issue. We would like to ask you several questions regarding physical or emotional abuse that may have happened to you within the last year.

Have you been physically hurt or threatened by someone (i.e., hit, slapped, kicked, sexually assaulted, etc.)? ❑ Yes ❑ No ❑ Decline
If yes, by whom_____ Total # of times_____

NUTRITION

Height:_____ Weight 1 year ago:_____ 6 months ago:_____ Current:_____

1. Do you follow a specific dietary regimen?
2. How would you describe your eating habits? (Food preferences: dairy, meat or poultry, fish, vegetables, fruits, sweets/cake/desserts.)
   _____
   _____

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NUTRITION

3. Do you have any personal, cultural or religious dietary restrictions? ❑ YES ❑ NO
   If yes, please describe:_____
4. Current Appetite Rating: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
5. Have you had a loss of desire to eat? ❑ YES ❑ NO
6. Any other information we should know?_____

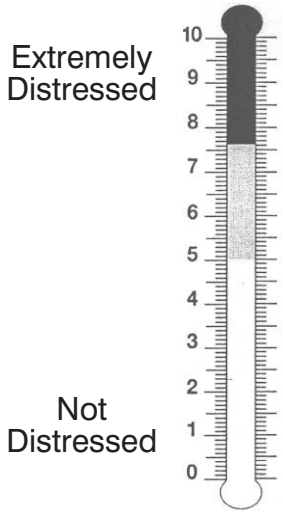
SPIRITUALITY AND RELIGION/CULTURE

1. Is spirituality important in your life? (Optional) ❑ YES ❑ NO
2. Do you have a religious affiliation? (Optional) _____
3. Would you like to see a Spiritual Care Counselor or Chaplain? ❑ YES ❑ NO
4. Are there religious or cultural beliefs that we should be aware of? ❑ YES ❑ NO
   If yes, please explain _____

COMPREHENSIVE DISTRESS RATING SCALE

1. Has your illness made you more aware of the stress in your life? ❑ YES ❑ NO

2. During the past week, how distressed have you been?



3. Please indicate your level of distress (see stress thermometer) for each area of distress in your life. 0 = none 10 = extreme

PRACTICAL CONCERNS
_____ Housing
_____ Financial
_____ Insurance
_____ Work/School
_____ Transportation
_____ Child Care

RELATIONSHIP CONCERNS
_____ With Partner
_____ With Children
_____ With Friends
_____ With Work
_____ With Family
_____ Sexual Concerns
_____ Other Concerns:_____

EMOTIONAL CONCERNS
_____ Worry
_____ Sadness
_____ Depression
_____ Nervousness

SPIRITUAL/RELIGIOUS CONCERNS
_____ Relating to God
_____ Loss of Faith
_____ Death and Dying
_____ Search for Meaning
_____ Other _____
_____

4. Have antidepressants, anti-anxiety or sleep medications been helpful in the past? ❑ YES ❑ NO
   If so, please indicate what was helpful. _____

INTEGRATIVE MEDICINE/COMPLEMENTARY THERAPY

Are you currently using complementary medicine/therapy? ❑ YES ❑ NO
If yes, please specify below:

TYPE OF THERAPY: _____
_____

NOTES

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INTEGRATIVE MEDICINE/COMPLEMENTARY THERAPY

NOTES

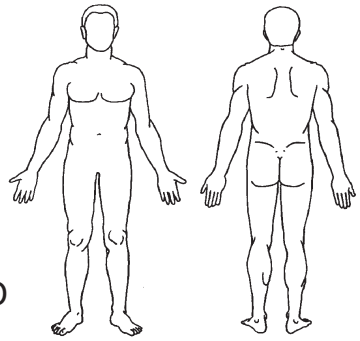
MODALITIES:	PLEASE DESCRIBE REASON FOR USING	WHEN STARTED OR STOPPED	USED HOW OFTEN
❑ Acupuncture			
❑ Massage			
❑ Guided Imagery			
❑ Meditation			
❑ Yoga			
❑ Support Groups			
❑ Reiki			
❑ Qi Qong			
❑ Art Therapy			
❑ Prayer			
❑ Other:			

PAIN

1. Do you currently have pain? ❑ YES ❑ NO
   For How Long:_____
   If yes, please rate pain on scale:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain



2. Please mark the areas where you have pain
3. Does your pain interfere with daily activity? ❑ YES ❑ NO
4. Which of the following apply to your pain or discomfort?

Qualities:	**Timing:**	**Improved by:**	**Made worse by:**
❑ Sharp	❑ Continuous	❑ Heat	❑ Heat
❑ Dull	❑ Off and on	❑ Cold	❑ Cold
❑ Cramping	❑ Most of the time	❑ Pressure	❑ Pressure
❑ Numbness	❑ Infrequent	❑ Exercise	❑ Exercise
❑ Pin and needles	❑ Brief periods of pain	❑ Position	❑ Position
❑ Burning ❑ Tingling	❑ Best time	❑ Food _____	❑ Food _____
❑ Knifelike ❑ Pressure	❑ Worst time_____	❑ Other _____	❑ Other _____

In order to improve your health, how willing are you to:
(Rate on a scale of 5 - very willing to 1 - not willing):

Educate yourself on your condition	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Significantly modify your diet	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Modify your lifestyle (work demands, sleep, etc.)	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Practice a relaxation technique	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Take several nutritional supplements each day	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Engage in regular movement	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Have periodic lab tests to assess your progress	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1

PATIENT'S SIGNATURE: _____ **DATE:** _____

IF COMPLETED BY SOMEONE OTHER THAN PATIENT:

NAME: _____ **RELATIONSHIP:**_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE GIVE IT TO THE NURSE.

PHYSICIAN'S SIGNATURE _____ **DATE** _____ **TIME** _____