# Cape Fear Valley Cancer Center Ambulatory Summary List

This form is to help your doctor give you better health care. It is completely confidential, and will be part of your medical record.

|  |  |
| --- | --- |
| NAME: | Date of Birth:  |
| Home Phone ( ) Cell Phone ( ) Work Phone ( ) |
| Occupation: | Retired? (circle one) Yes / No |
| Primary Care Doctor: | Doctor who referred you to us: |
| Other Doctors to receive Oncology Treatment Notes if any: |  |
| Pharmacy Name: | Pharmacy Address: |
| Pharmacy Phone ( ) |
| Emergency Contact Name: Home Phone ( ) |
| Relationship to you: Cell Phone ( ) Work Phone ( ) |
| Marital Status: (circle one) Married / Single / Widowed / Separated / Divorced |
| I live with: (circle one) Spouse / Significant Other / Alone / Family / Supervised Living / Other |

## Medical History (circle all that apply)

|  |  |  |
| --- | --- | --- |
| No other medical problems | GI Bleeding | Fibromyalgia |
| Chicken Pox / Shingles | Stomach Problems | Arthritis |
| Measles / Mumps / Rubella | Ulcerative Colitis/Crohn’s | Gout |
| Heart Attack | Gall Bladder Problems | Thyroid Problems |
| High Blood Pressure | Jaundice / Hepatitis / Liver Problem | Diabetes / Sugar Problems |
| Heart Murmur | Kidney / Bladder Problems | Eczema / Psoriasis |
| High Cholesterol | Sexual Problems | Prostate Problems |
| Congestive Heart Failure | HIV / Aids | Breast Problems |
| Pacemaker / Defibrillator | Seizure Disorder / Convulsions | Anemia / Blood Problems |
| Stroke | Nervous Disorder | Blood Transfusions |
| Asthma | Depression | Previous Cancer |
| Emphysema / COPD | Mental Illness | Nonmedical Radiation Exposure |
| Pneumonia | Dementia | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Glaucoma  | Headaches | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cataracts | Chronic Pain | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

### For Women Only

|  |
| --- |
| Age at onset of menstrual period: Date of last menstrual period:  |
| Is there a possibility that you are currently pregnant? Yes No NA |
| Ever taken birth control pills? Yes / No How long? \_\_\_\_\_\_\_ years |
| Number of pregnancies: Number of live births: |
| Ever taken hormone replacement therapy? Yes / No How long? \_\_\_\_\_\_\_\_years |

###  Prior Surgeries or Hospitalizations

|  |  |
| --- | --- |
| Month / Year | Operation or Hospitalization |
|  |  |
|  |  |
|  |  |
|  |  |

### Prior Cancer Treatments

|  |  |
| --- | --- |
| Month / Year | Type of Chemotherapy or Radiation Site |
|  |  |
|  |  |
|  |  |

### Allergies

|  |  |
| --- | --- |
| List all allergies: Food / Drug / Latex  | Reaction and Severity |
|  |  |
|  |  |
|  |  |

### Medications

|  |
| --- |
| List all medications you currently take, or provide list to nurse: |
| Medication | Dose | Times / day | Medication | Dose | Times / day |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

### Vitamins, Minerals, Herbs, Supplements

|  |  |  |
| --- | --- | --- |
| Vitamin/mineral/herb/supplement | Dose | Times per day |
|  |  |  |
|  |  |  |
|  |  |  |

### Habits

|  |
| --- |
| Do you use: (circle all that apply) Cigarettes / Cigars / Chewing Tobacco / Snuff |
| Number of years: \_\_\_\_\_\_\_ Quit date: \_\_\_\_\_\_\_ If cigarettes, packs per day: \_\_\_\_\_\_\_  |
| Do you use alcohol: (circle one) Yes / No |
| Number of Years: \_\_\_\_\_\_\_ Quit Date: \_\_\_\_\_\_\_ Drinks per Week: \_\_\_\_\_\_\_  |
| Have you used recreational drugs: (circle one) Yes / No |

### Please list family members with any type of cancer or blood disorder:

## Review of Symptoms (circle all that apply)

|  |  |
| --- | --- |
| **Constitutional** | **Musculoskeletal** |
| Fevers | Tire easily | Difficulty walking | Painful legs / feet |
| Night sweats |  | Difficulty standing | Back pain / ache |
| Recent weight loss # lbs \_\_\_\_\_\_\_ time frame \_\_\_\_\_\_ | Recent weight gain # lbs \_\_\_\_\_\_\_  time frame \_\_\_\_\_\_ | Difficulty lifting | Neck pain / stiffness |
| Joint aches / stiffness |  |
|  |  |
| **Cardiology** | **Respiratory** |
| Chest pain | Feeling you might pass out | Shortness of breath | Cough producing blood |
| Ankle swelling  | Rapid/irregular heart beat | Dry cough | Cough producing sputum |
| **Gastrointestinal** | **Genitourinary** |
| Loss of appetite | Black/tarry stools | Painful urination | Unable to control urine |
| Heartburn / indigestion | Bloody stools | Difficulty emptying bladder | Having to get up at night to urinate |
| Stomach pain/discomfort | Diarrhea |
| Gas or cramps | Constipation | Frequent urination | Bladder infections |
| Changes in taste | Nausea | Blood in urine | Vaginal itching / discharge |
| Trouble swallowing | Vomiting |  | Sexual problems |
| **Eyes, Ears, Nose, Throat, Mouth** | **Neurologic** |
| Recent vision changes | Hearing loss | Difficulty concentrating | Dizziness |
| Tooth pain | Hearing aid(s) | Numbness in hands / feet | Memory changes |
| Other dental problems | Ringing in ears | Headaches |  |
| Hoarseness | Ear pain |  |  |
| Sore throat | Nosebleeds |  |  |

## Psychosocial Distress Screening

I am currently experiencing (circle number corresponding to your distress level):

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NoDistress |  |  |  |  |  |  |  |  |  | ExtremeDistress |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

### Please circle any of the items below that are causing distress:

|  |  |  |  |
| --- | --- | --- | --- |
| **Practical Problems** | **Family Problems** | **Emotional Problems** | **Spiritual / Religious** |
| Housing | Dealing with partner | Worry | Any concerns |
| Money / Financial | Dealing with children | Fears |
| Insurance | Dealing with other | Sadness |
| Work |  | Depression |
| School |  | Nervousness |
| Transportation |  | Loneliness |
| Child Care |  |  |

Other problems, things you would like us to know:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For Office / Nursing Use Only

Physician: HB SS IP TW SGD KB SM KM KF Consult Type: NEW R/C

Cancer Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ht: \_\_\_\_\_\_\_\_ Wt: \_\_\_\_\_\_\_\_\_\_ T: \_\_\_\_\_\_\_\_ P:\_\_\_\_\_\_\_ R: \_\_\_\_\_\_\_\_ B/P: \_\_\_\_\_\_\_\_

Patient Learns Best By: Reading Listening Demonstration

Pain: Y N Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Level: \_\_\_\_\_\_\_\_ Worst(24 hrs): \_\_\_\_\_\_\_\_ Least(24 hrs):\_\_\_\_\_\_\_\_

Constant / Intermittent / Brief

Describe Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes better: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ makes worse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature / Title:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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