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DUKE UNIVERSITY HEALTH SYSTEM

Patient Name:

MRN:

Sarcoma
Multi-disciplinary Program

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Patient Information Form

Patient Profile

Date:_____/_____/_____

Name_____ **(Please circle: Miss/Ms./Mrs./Mr./Dr./Rev.)**

Hm. Phone:_____ **Wk. Phone:**_____ **Cell phone:**_____

Spouse's Name/Significant Other:_____ **Spouse's cell ph:**_____

What doctor sent you here today?
Name: _____
Address: _____
City _____ State_____ Zip_____
Phone _____

Do you have a family doctor?
Name: _____
Address: _____
City _____ State_____ Zip_____
Phone _____

Please list other doctors you see.
Name: _____ Specialty_____
Address: _____
City _____ State_____ Zip_____Phone_____
Name:_____ Specialty_____
City _____ State_____ Zip_____ Phone _____

Next of kin or close friend (NON-spouse) who generally would know your whereabouts:

Name: _____ Telephone: _____
Address: _____ City, State: _____
Relationship: _____

Present Illness:

Why are you here?_____

_____

When did you first notice this problem?_____

_____

Have you had any tests for this problem(s)?

	Yes	No	When	Where
X-rays	___	___	_____	_____
CT Scan	___	___	_____	_____
MRI	___	___	_____	_____
Bone Scan	___	___	_____	_____
Other Imaging	___	___	_____	_____

Do you have insurance? Y N **Does it pay for prescriptions?** Y N

If yes, what is your prescription co-pay? $_____ OR _____%

Preferred pharmacy: Name:_____ **Ph. No.:**_____

Medical History:

Past illnesses or chronic medical problems:

	Year		Year		Year
Emphysema/Bronchitis	____	Kidney Disease	____	Pneumonia	____
Lupus/Scleroderma	____	Kidney Stones	____	Asthma	____
Ulcerative Colitis	____	Thyroid Disease	____	Stroke	____
High Blood Pressure	____	Multiple Sclerosis	____	Tuberculosis	____
Gall Bladder Disease	____	Cirrhosis of Liver	____	Arthritis	____
Peptic Ulcer Disease	____	Heart Attack	____	Depression	____
Rheumatic Heart Disease	____	Heart Failure	____	Hepatitis	____
Urinary Infection	____	Irregular heart rate	____	Jaundice	____
Migraine Headaches	____	Diabetes/Sugar	____	Anemia	____
Seizures/Convulsions	____	Glaucoma	____	Other blood	____
Crohn's Disease	____	Other: _____	____	abnormality	

Cancer Diagnosis: **Type** **Date** **Hospital**

_____

_____

Previous Radiation: **Area Treated** **Date** **Hospital**

_____

_____

Previous Chemotherapy: Type Date Hospital

Past Operations: Type Date Hospital
and Biopsies

Medication History:

Medicines you are now taking:

Drug name	Dose	How Often?	For What?

Allergies to medicines:

Drug name	What happens when you take it?

Latex Allergy? Y N

Review of systems:

Symptoms: Please circle any of the symptoms below which you've had in the **last month**:

- Night sweats/fevers
- Changes in sleeping pattern
- Easy bruising or unusual bleeding
- Skin rash or itching
- Hoarseness or change in voice
- Sores in mouth or lips
- Sinusitis or postnasal drip
- Enlarged or swollen lymph glands
- Chest pain(s)
- Palpitations or heart fluttering
- Cough
- Coughing up blood
- Shortness of breath
- Nausea/vomiting
- Change in food taste/smell
- Change in appetite
- Dry mouth
- Belching
- Bloating
- Indigestion/Heartburn
- Change in weight
- Difficulty swallowing
- Hemorrhoids or irritation
- Change in bowel habits or rectal bleeding
- Foul-smelling urine
- Blood in urine or stool
- Pain or burning with urination
- Frequency of urination
- Decrease in size or force of urine stream
- Impotence or difficulty with sex
- Bone or Joint pain
- Mood changes/depression
- Anxiety
- Changes in speech
- Changes in memory
- Loss of balance
- Seizures
- Dizziness
- Numbness/tingling in fingers/toes
- Headaches
- Hearing Loss
- Marked fatigue or weakness
- Eye trouble, double vision

Family History

Relation	Age	Medical Problems	If deceased, age & cause of death
Father			
Mother			
Brothers: #			
Sisters: #			
Children: #			

Other relatives with cancer/ type of cancer:

_____

_____

_____

Social History:

Tobacco Use:

Type	**How much per day?**	**How many years?**	**If you quit, when?**

_____

Alcohol Use:	**Type**	**How much?**	**If you quit, when?**

_____

Education: 1 2 3 4 5 6 7 8 1 2 3 4 1 2 3 4 over 4
(Circle Highest) Elementary High College

What language do you speak? English Other_____

What language do you read? English Other_____

How do you learn best? Written Visual Listening

Occupation (if retired, former occupation): _____

Are you on disability? N Y (If yes or if unable to work, when was your last day of work? _____)

Marital Status: ____ Single ____ Widowed _____ Married _____Divorced

Living Situation: ____ Live alone ____Live with other ____Family/Friend/Support nearby

Race/Ethnicity: _____

The Patient Self-Determination Act of 1990 requires all health-care providers to inform you of the right to accept or refuse medical treatment. More information on your options regarding your treatment decision, preparing a living will, or assigning a Health Care Power of Attorney, is available. If you would like further information on this, please ask a member of the Oncology staff (Front Desk/ Clinic Service/ Nurses/ Social Workers).

Do you currently have a living will or health care power of attorney? ___Yes ____No

Functional Capacity:

Over the past month, how would you rate your activity level?

_____Normal, with no limitations.
_____Not your normal self, but able to be up and about with fairly normal activities.
_____Not feeling up to most things, but in bed less than half the day.
_____Able to do little activity and spend most of the day in bed or chair.
_____Pretty much bedridden, rarely out of bed.

Social Worker Needs:

Do you need to see a social worker regarding any of the following ? (Please check all that apply)

_____Lodging

_____Equipment needs (i.e., Home oxygen, hospital bed, walker, etc.)

_____Transportation

_____ Medications

_____ Other (Insurance, disability)

Are you currently receiving home health care? _____Yes _____No

If yes, name of agency: _____

THIS INFORMATION HAS BEEN REVIEWED WITH THE PATIENT.

Patient signature: _____

Provider signature: _____

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