

Hunterdon Hematology Oncology, LLC
2100 Wescott Drive, Flemington, NJ 08822
www.HunterdonCan.com

PATIENT HISTORY AND SELF ASSESSMENT FORM

Date: _____ Race: _____

Name: _____

D.O.B.: _____ Age: _____

Primary Language: _____

Diagnosis: _____

Primary Physician: _____

Referring Physician: _____

Allergies: _____

Shellfish: Yes / No Latex: Yes / No Iodine: Yes / No

Do you smoke? Yes / No

| PLEASE INDICATE YES/NO TO THE FOLLOWING: | YES | NO |
|---|-----|----|
| HEART DISEASE (heart attack, angina, CHF) | | |
| PACEMAKER | | |
| STROKE | | |
| DIABETES (sugar problems) | | |
| HYPERTENSION (high blood pressure) | | |
| EMPHYSEMA | | |
| TUBERCULOSIS | | |
| PNEUMONIA | | |
| PEPTIC ULCER | | |
| BOWEL PROBLEMS | | |
| HEPATITIS | | |
| URINARY PROBLEMS (kidney/bladder) | | |
| HISTORY OF SEXUAL OR PHYSICAL TRAUMA | | |
| ARE YOU/COULD YOU BE PREGNANT? | | |
| VENEREAL DISEASE (syphilis, gonorrhea) | | |
| GYNECOLOGICAL PROBLEMS (infections, etc) | | |
| DEPRESSION OR MENTAL ILLNESS | | |
| HAVE YOU EVER ATTEMPTED SUICIDE? | | |
| HISTORY OF SUBSTANCE ABUSE | | |
| THYROID PROBLEMS | | |
| SEIZURES | | |
| PREVIOUS CHEMOTHERAPY | | |
| PREVIOUS RADIATION THERAPY | | |
| PREVIOUS SURGERIES | | |
| FAMILY HISTORY OF CANCER | | |
| LAST TETANUS SHOT - Date: | | |

| PAIN ASSESSMENT SCALE: | | Location _____ | | | | | | | | | | |
|------------------------|---|----------------|---|---|---|----------|---|---|---|--------|--|--|
| NONE | | MILD | | | | MODERATE | | | | SEVERE | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | |

MD NOTES: (BELOW TO BE COMPLETED BY THE PHYSICIAN)

HT _____ WT _____
TEMP _____ PULSE _____
RESP _____ BP _____
PLAN OF CARE/Instructions to Staff
_____ HBV/HCV - Chemo pt only
_____ CBC w/ diff and slide
1. _____
2. _____
3. _____
4. _____

Cessation Counseling _____ time
Protocol YES NO NA
FRAP YES NO
Is staging form appropriate? YES NO
Patient to follow up with Doctor/PA _____

Refer to: _____
File folder size _____ DOB of patient on letter
____ S ____ L _____
Please cc Cancer Registry on Consult Letter
MD Signature: _____