Part I – To be Completed by Patient

Name: _____ Date: _____

Street Address/Apt #: _____

City, State, Zip Code: _____

Telephone: Home _____ Work _____

Cellular _____ Pager _____

SSN: _____ Date of Birth: _____ Gender: M_____ F____

Race: _____ Marital Status: Single ____ Married____ Divorced ___ Widowed____

Living Arrangements:

Lives alone _____ With spouse/SO_____ With parents _____ With children_____

Other: _____

Children: Y _____ N____ How many?_____ Sons _____ Daughters_____

Occupation: _____ Retired:____ Disability: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Telephone: Home _____ Work _____

Cellular _____ Pager_____

Referring Physician: _____ Family Physician:_____

Other Physician(s): _____

_____

Reason for today's visit (patient's own words):

_____

_____

Henrico Doctors' Hospital
The Cancer Center Evaluation Clinic
Patient Assessment Form

Medical History:

_____ Heart disease/heart attack
_____ High blood pressure
_____ Pacemaker
_____ Stroke/TIA
_____ Lung disease/emphysema/asthma/TB
_____ Headaches
_____ Pneumonia
_____ Diabetes
_____ Kidney disease
_____ Hepatitis, type_____
_____ Gastrointestinal disorder
_____ Thyroid disease/endocrine disorder
_____ Bleeding/blood abnormality
_____ Blood clots/DVT/Pulmonary embolus
_____ Anemia
_____ Other:_____

_____ Arthritis
_____ Connective tissue disorders/Lupus
_____ Seizure
_____ Rheumatic fever
_____Excessive sweating/night sweats
_____Dental/gum disease
_____Depression/anxiety/psychological disorder
_____ Liver disease
_____Injuries
_____Dementia

_____ Cancer (type)_____

_____Chemo: type/when/where/MD _____

_____ Radiation: type/when/where/MD _____

Immunizations:

		Date
Influenza	Y____ N ____	_____
Pneumonia	Y____ N ____	_____
Other: _____		_____

Surgical History (please list surgery, approximate date of surgery, surgeon, and hospital where performed):

_____

_____

_____

_____

Non-Surgical Hospitalizations:

_____

_____

_____

Allergies (Food, Drug, Latex): _____

_____

Current Medications (Including over the counter and herbal remedies):

Medication Dose/Frequency

_____

_____

_____

_____

_____

Social History:

Tobacco use: Cigarettes/cigars _____ chewing tobacco _____
Do you currently smoke? Y____N _____ Packs/Day _____ # of years _____
Attempts to quit: _____ Measures tried_____
Smoked in the past? Y ____ N ____ Packs/Day _____ # of years _____

Alcohol Use: Y ____ N ___
If yes, type/how much?_____
Do you experience facial or chest flushing when drinking alcohol? Y _____N _____

If no, did you drink in the past? Y_____ N____
When did you quit? _____
History of alcohol abuse: Y____N____
If yes, did you undergo treatment? _____

Recreational Drug Use: Y _____ N_____Type_____ Frequency _____
If no, do you have a history of drug use? Y ____N____ If yes, please provide history:

_____

Environmental/Occupational exposures (Asbestos, etc): _____

Military history:_____

Travel outside of North America (when/where):

_____

_____

Religion: _____

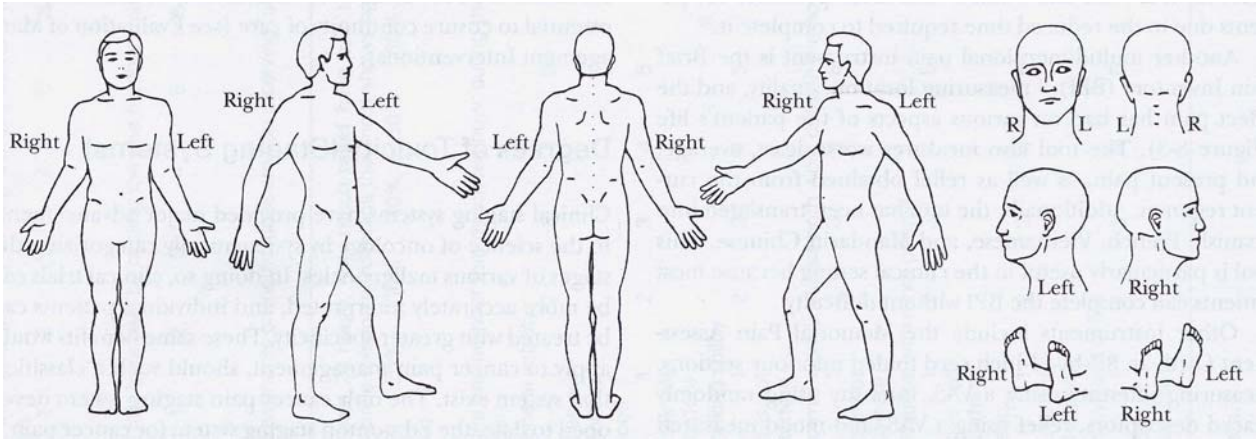
Spiritual/Cultural Needs: _____None _____ Food Restrictions _____No Blood/Blood Products
Other:_____

Family History

	Living	Age of Death	Cancer	Heart Disease	Stroke	Blood Disorder	Other
Father	Y / N						
Mother	Y / N						
Brother/Sister	Y / N						
Brother/Sister	Y / N						
Other	Y / N						
Other	Y / N						
Other	Y / N						

Initial Pain Assessment

I. Location: Patient or nurse marks diagram



II. Intensity: Patient rates the pain. Numeric scale used.

NUMERIC SCALE: Use this pain scale for adults

0 1 2 3 4 5 6 7 8 9 10

No Pain **Moderate Pain** **Worst possible**

Present pain score: _____

Highest level the pain gets: _____Lowest level the pain gets: _____

Acceptable level of pain: _____

What makes the pain better? _____

What makes the pain worse? _____

Part II – To be completed by MD/NP

Review of Systems/PE

TEMP	PULSE	RESP	B/P	WT	HT

Chief Complaint:

_____

_____

Review of Systems:

General: Mood chills, weakness, fatigue, fever, night sweats, appetite, sleep pattern, Weight loss/gain; time frame_____

Comments: _____

HEENT: Headaches, dizziness, syncope, loss of consciousness, visual changes, discharge, bleeding, tinnitus, hearing loss, vertigo, sore throat, dysphagia, hoarseness, ulcers, pain, masses, nodes, swelling, tenderness, neck pain/stiffness

Comments: _____

Breasts: Dimples, discharge, masses, pain, tenderness, discoloration, self-exam pattern, last mammogram: _____

Comments: _____

Cardiovascular: Chest pain, palpitations, murmur, dizziness, exertional dyspnea, edema, SOB , orthopnea, fatigue, cyanosis, hypertension, pulse: regular/irregular

Comments: _____

Respiratory: Dyspnea, cough, sputum, hemoptysis, stridor, wheezing, oxygen/inhaler

Comments: _____

GI: Pain, nausea, vomiting, constipation, diarrhea, blood, melena, bloating, ascites, ostomy, change in bowel habits, change in appetite

Last stool hemoccult_____Last DRE_____ Last colonoscopy/MD_____

Comments: _____

GU: Pain, nocturia frequency, dysuria, anuria, polyuria, enuresis, change in stream, urgency, incontinence, retention, discharge, flank pain, suprapubic pain, urine: color/odor change, pyuria, hematuria, lesions, masses, swelling
Male patient: _____testicular pain _____prostate problems Last PSA_____

Comments: _____

GYN: Bleeding, discharge, lesions, sexually active, oral/other contraceptives, dysmenorrhea
Date of last PAP smear _____Menses: age at onset_____regularity___LMP_____
Age at menopause _____ERT_____
Pregnancies: # _____ live births _____ miscarriages _____ abortions _____
Age at first term pregnancy _____
Could patient be pregnant now? _____

Comments: _____

Skin: rash, lesions/sores, bruising, dryness, pruritus, non-healing scab, moles

Comments: _____

Lymph/Heme: anemia, bleeding tendency, easy bruising, lymphadenopathy extremity edema

Comments: _____

Musculoskeletal: joint pain, muscle pain, bone/back pain, swelling, weakness, change in strength, deformity, ROM, prosthesis, assistive device

Grade ADL by: 0=Independent; 1=Needs equipment; 2=Needs person; 3=Needs equip/person; 4=Dependent

_____ Feeding _____ Bathing _____ Ambulation _____ Toileting _____ Dressing

Comments: _____

Neuro: memory loss, confusion, headaches, seizures, anesthesias, parasthesias, syncope, weakness, vertigo, numbness, tingling, tremors, paralysis, change in sensation, change in coordination

Comments: _____

Psychologic: altered mood, anxiety, difficulty concentrating, irritability, depression, suicidal thoughts, sleep disturbances

Comments: _____

Physical Examination

CONSTITUTIONAL/PSYCH:
General appearance: _____Normal_____Age _____Race _____Well nourished
_____Poorly nourished _____Obese_____Thin _____Frail ___ Chronically ill ___ Pale
Mood/Affect _____ Normal
Orientation _____ Normal x 4
Memory _____ Normal
Judgment/Insight _____ Normal

HEAD: _____ Normal _____ Abnormal _____

EYES:
Conjuctivae/Lids _____ Normal _____ Abnormal _____
Sclera _____ Normal _____ Abnormal _____
Pupils _____ Normal _____ Abnormal _____
EOMs _____ Normal _____ Abnormal _____

EARS, NOSE, MOUTH, THROAT:
External inspection _____ Normal _____ Abnormal _____
Hearing _____ Normal _____ Abnormal _____
Nose _____ Normal _____ Abnormal _____
Mouth _____ Normal _____ Abnormal _____
Oropharynx _____ Normal _____ Abnormal _____

NECK:
Trachea _____ Normal _____ Abnormal _____
Thyroid _____ Normal _____ Abnormal _____
Pulses _____ Normal _____ Abnormal _____

RESPIRATORY:
Effort _____ Normal _____ Abnormal _____
Percussion _____ Normal _____ Abnormal _____
Palpation _____ Normal _____ Abnormal _____
Auscultation: _____ Normal _____ Abnormal _____
___ Rales ___ Rhonchi ___ Wheezes ___ Rubs ___ Crackles

CHEST/BREAST:

Examination: _____ Normal _____ Abnormal _____

_____ Symmetry _____ Retraction _____ Dimpling _____ Discharge

_____ Nipple _____ Scars

Palpation _____ Normal _____ Masses _____ Tenderness

_____

CARDIAC:

___ Normal ___ Abnormal ___ Rate/Rhythm ___ Murmur ___ S3 ___S4 ___Rub ___ Click

_____

ABDOMEN

_____ Normal _____ Bowel sounds ____ Masses _____ Guarding _____ Tenderness

_____ Bruits _____ Distention

_____ Organomegaly _____ Hernia ____ Flank pain

_____ Hemoccult _____ DRE

_____

GU: _____ Normal _____ Abnormal _____

_____

NEURO:

Cranial Nerves II-XII _____ Normal _____ Abnormal _____

Reflexes _____ Normal _____ Abnormal _____

Sensation _____ Normal _____ Abnormal _____

EXTREMITIES:

_____ Normal ____ Edema ____ Varicosities ____ Cyanosis ____ Clubbing ____Pulses

_____ Temperature ____ Strength

_____

MUSCULOSKELETAL:

Alignment _____ Normal _____ Abnormal _____ Tenderness

ROM _____ Normal _____ Abnormal _____ Limitation ____ Crepitus

_____ Contracture _____ Pain

Strength/Tone _____ Normal _____ Abnormal ___ Flaccid ___ Spastic ___ Atrophy

Gait/Posture _____ Normal _____ Abnormal _____

Functional Status: _____

SKIN:

_____ Normal _____ Abnormal _____

_____ Jaundice _____ Cyanosis _____ Lesions _____ Rash _____Petechiae

_____ Purpura

_____ Normal _____ Abnormal _____ Turgor ___ Induration ___ Nodules

_____

LYMPH:

_____ Normal _____ Abnormal _____

____ Size ____ Tenderness _____ Location

Impression:

Plan:

Signature: _____ Date: _____