Name: ____SSN: _______________________

Complaint: Cancer

Name of the Oncologist ________________________

Date of Diagnosis Month__________ Year__________

Severity:

On a scale of 1 to 10 (0 being no pain and 10 being the worst pain imaginable), how would you rate your pain now? _____________

Status:

Stable	Improving	Worsening
Clinically Free of Disease	Remission	Relapse

Initial Symptoms:

Anemia	Fever	Pain	None
Anorexia	Mass/Lump	Shortness of Breath	
Weight Gain	Fatigue	Nausea	Skin Changes
Weight Loss	Other______________		

Risk Factors:

Exposure to Hazardous materials   History of Cancer

None

Family History of Cancer (who) ____________   History of Tobacco Use

Other______________

Current Performance Status:

0- Fully Active   3- Limited Self Care, Confined to Bed/Chair

1- Restricted in Physical Activity   4- Completely Disabled

2- Ambulatory, Capable of Self Care

Name: ____SSN: ________________________

Please answer the next questions ONLY if applicable.

Date of First Chemotherapy Treatment __________________

Date of Last Chemotherapy Dose ______________________

Date of Last Radiation _______________________

Adverse Effects from last Treatment:

Oral Ulcers	Diarrhea	Fever	Infections
Bleeding Gums	Dyspnea	Flushing	Joint Pain
Bone Pain	Easy Bruising	Hair Loss	Nausea
Chills	Fatigue	Headache	Nose Bleeds
Decreased Appetite	Febrile Neutropenia	Hot Flashes	Rash

Other_______________________________________

Associated Symptoms/ Pertinent negatives

Abdominal pain	Constipation	Headache	Poor Fluid Intake	Sweats
Anorexia	Cough	Increased Thirst	Red/Purple Spots	Vomiting
Bone Pain	Diarrhea	Insomnia	Problems Coping	Weight Loss
Bruising/Bleeding	Dizziness	Mouth Sores	Problems Urinating	Weight Gain
Chest Pain	Fatigue	Nausea	Rash/ Hives	Chills
Fever	Pallor	Shortness of Breath	No Associated Symptoms	