



Medical History

1.) Name: _____ Date: _____

Current Primary Care Physician: _____

University of Colorado Cancer Center Oncologist: _____

How did you hear about us? (name and job title, if applicable): _____

DOB _____ Age _____ Gender: M F

Check ALL spaces below which apply to you. (If checked please include explanation and date of occurrence)

2.) Present Medical History

Explanation and/or date:

Back/Neck Pain or Problems _____

Shoulder/Chest Pain or Problems _____

Foot/Ankle Pain or Problems _____

Knee/Hip Pain or Problems _____

Arthritis _____

Swollen/Stiff/Painful Joints _____

Lymphedema _____

Changes in Sensation _____

Changes in Balance or Balance Problems _____

Stroke _____

Nausea or Vomiting _____

Anemia _____

Fallen in last 6 weeks? Feel this was related to cancer or treatment?

Describe: _____





___ Increased Anxiety/Depression _____

___ Epilepsy _____

___ Vision/Hearing Problems _____

___ Breathing Problems _____

___ Other _____

Past Operations: (starting with the most recent)

1.) _____ Date: _____

2.) _____ Date: _____

3.) _____ Date: _____

4.) _____ Date: _____

5.) _____ Date: _____

Hospitalizations (if any): (reason) _____

3.) Current Cancer Treatment

Current Cancer Diagnosis: _____

Date of Diagnosis: _____

a.) Are you currently receiving, or plan to receive, chemotherapy? **Y / N**

Type:

Description (dosage, schedule, etc. If known):

b.) Are you currently receiving, or plan to receive, radiation therapy? **Y / N**

Description:

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c.) Do you have a surgery planned? **Y / N**

Description:

d.) Are you currently receiving, or plan to receive, other cancer related treatments? **Y / N**

Description:

4.) Past Cancer Treatment (answer to best of your ability)

Past Cancer Diagnoses (with date of diagnosis):

In the past 6 months:

a.) Did you receive chemotherapy? **Y / N**

Type:

Description (date, dosage, schedule, etc. If known):

b.) Did you receive radiation therapy? **Y / N**

Description:

c.) Did you have surgery? **Y / N**

Description:

d.) Did you receive other cancer related treatments? **Y / N**

Description:

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