Highlands Oncology
Patient History

Name (First and Last) ____ Today's Date: ______________

Date of Birth: ______________ Referring Physician: ________________________________

☐ Male ☐ Female Primary Care Physician: ________________________________

OB/Gyn Physician: ________________________________

Other Physicians: ________________________________

Reason for Today's Visit: ____

____

Personal Medical History: Please check all that apply and include year of diagnosis

	Condition	Treating Doctor	Date of Diagnosis
☐	Alcohol dependence		
☐	Anemia		
☐	Angina/chest pain		
☐	Anxiety		
☐	Asthma		
☐	Blood disorder Type________		
☐	Cancer Type_________		
☐	Cardiac Stent		
☐	Cirrhosis, due to alcohol		
☐	Colostomy/ileostomy		
☐	Coronary artery disease		
☐	Congestive heart disease/CHF		
☐	Chronic obstructive pulmonary disease/COPD		
☐	Depression		
☐	Diabetes Type__________		
☐	Dialysis		
☐	Drug dependence, Drug name________________		
☐	Emphysema		
☐	GERD		
☐	Heart arrhythmia		
☐	Heart attack/MI		

	Condition	Treating Doctor	Date of Diagnosis
☐	Heart valve disease		
☐	Hepatitis,Type__________		
☐	High blood pressure		
☐	High cholesterol		
☐	HIV/AIDS		
☐	Inflammatory bowel disease		
☐	Kidney disease/renal failure, Stage________		
☐	Neuropathy		
☐	Organ transplant, Type _________		
☐	Pacemaker		
☐	Parkinson's disease		
☐	Paralysis		
☐	Pneumonia		
☐	Rheumatoid arthritis		
☐	Schizophrenia		
☐	Seizure disorder		
☐	Stroke		
☐	Thyroid disease		
☐	Tuberculosis		
☐	Ulcer Type__________		
☐	Vertebral fractures		
☐	Other_______________		

Hospitalizations/Surgeries: Please list all hospitalizations and surgeries

	Date	Reason for Hospitalization or Type of Surgery	Where	Doctor
1.				
2.				
3.				
4.				
5.				
6.				

Previous Treatment for Cancer (if applicable) When, Where

Radiation Therapy: ____

Chemotherapy: ____

Hormone Therapy: ____

Highlands Oncology Group Patient History

Name (First and Last) ______________________________ Date of Birth ____________________

Immunizations: Please check previous immunizations received and include date of last vaccine if known.

Flu ☐	Hepatitis B ☐
Shingles ☐	Pneumonia ☐

Medications: Please list current prescriptions and over-the-counter medications, as well as herbals, supplements and vitamins.

	Medication	Dose	Frequency	Start Date	Reason
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					

Pharmacy Name and location ____

Allergies

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list the medications that you are allergic to and the type of reaction:

____

____

____

____

Are you allergic to:

Contrast/IV dye for scans ☐ Yes ☐ No

Latex: ☐ Yes ☐ No

Tape: ☐ Yes ☐ No

Vaccines: ☐ Yes ☐ No If yes, please list the type of vaccine: ____________________

Other allergies: ☐ Yes ☐ No

If yes, please list other allergies: ____

Blood Transfusions

Have you ever had a blood transfusion? ☐ Yes ☐ No Reason: ______________________________

If yes, did you have a reaction? ☐ Yes ☐ No

Date of last blood transfusion: ________________

patienthistoryform updated 12/2018

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Name (First and Last) ____ Date of Birth ___________________

Screenings

	Date	
Last mammogram (female)		
Last PAP smear (female)		
Last colonoscopy or sigmoidoscopy		
Last bone density scan		
Other		

Social History

Living arrangement: ☐ Single ☐ Married ☐ Partnered ☐ With family ☐ Separated ☐ Divorced ☐ Widowed ☐ Care Facility

Number of pregnancies: _____________ Number of children: ______________

Occupation (previous if retired): ____ ☐ Retired

Have you served in the military? ☐ Yes ☐ No If yes, dates of service ________________

Do you currently use tobacco products:

☐ Yes Number per day: ☐ Cigarettes: _______ ☐ Cigars:_________ ☐ Pipe:_________ ☐ Chewing tobacco:_________

For how many years have you used the above tobacco product? _________________________

☐ No Have you ever used tobacco products in the past? ☐ Yes ☐ No

When did you quit? ___________ For how many years did you use tobacco products? ______________

How many servings of wine, beer or other alcoholic beverage(s) do you drink per day? _________Per week?__________

Do you have a history of alcoholism? ☐ Yes ☐ No

Have you used illegal drugs? ☐ Yes ☐ No

If yes, which ones? ____

Do you use marijuana? ☐ Yes ☐ No

What do you do for exercise?_________________________How many times per week? ___________________________

Do you have an Advance Directive, Living Will, or Power of Attorney? ☐ Yes ☐ No

If you have one of these, please bring to your next appointment.

Family history of cancer

	Type of Cancer	Age at Diagnosis	Alive or Deceased
Father			
Mother			
Brother			
Sister			
Son			
Daughter			
Grandfather			
Grandmother			
Uncle			
Aunt			

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Symptoms: Please check all that apply or *None*

Do you have pain? ☐ Yes ☐ No
If yes, where? __________________ Intensity (1-10): __________________ Frequency: __________________

Constitutional:
- ☐ Appetite
  - ☐ Good
  - ☐ Fair
  - ☐ Poor
- ☐ Weight loss
- ☐ Fatigue
- ☐ Generalized weakness
- ☐ Fever
- ☐ Altered taste
- ☐ Chills
- ☐ Night sweats
- ☐ Hot flashes
- ☐ None

Immunologic/Infections:
- ☐ Severe allergic reactions
- ☐ Frequent or severe infections
- ☐ Pollen allergies/hay fever
- ☐ None

Hematologic/Lymphatic:
- ☐ Easy bruising
- ☐ Abnormal bleeding
- ☐ Enlarged lymph nodes
- ☐ None

Eyes:
- ☐ Glasses/contacts
- ☐ Blurred vision
- ☐ Double vision
- ☐ Dry eyes
- ☐ None

Ears, nose, mouth, throat:
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sinus tenderness
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Bleeding gums
- ☐ Mouth sores
- ☐ Dry mouth
- ☐ None

Cardiovascular/Heart:
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swollen feet, ankles or hands
- ☐ None

Respiratory/Lungs:
- ☐ Cough
- ☐ Sputum or phlegm production
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ None

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Difficulty swallowing
- ☐ Frequent heartburn
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stools
- ☐ Change in bowel habits
- ☐ Hemorrhoids
- ☐ None

Genitourinary:
- ☐ Pain/burning with urination
- ☐ Excessive nighttime urination
- ☐ Slow starting or stopping
- ☐ Urgency
- ☐ Unable to hold urine
- ☐ Blood in the urine
- ☐ None

Gynecologic:
- ☐ Vaginal dryness
- ☐ Vaginal bleeding
- ☐ Vaginal discharge
- ☐ Pelvic pain

GYN History:
- ☐ First menstrual peroid, age _____
- ☐ Last menstrual peroid, age _____
- ☐ Menopause, age _____
- ☐ Number of pregnancies _____
- ☐ Number of live births _____
- ☐ Estrogen use Yes ___ , No ___
  Number of years _____
- ☐ Contraception, type used
  ____

Musculoskeletal:
- ☐ Bone pain
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Swollen joints
- ☐ Back pain
- ☐ Limited range of motion
- ☐ None

Integumentary/Skin:
- ☐ Rash
- ☐ Itching
- ☐ A sore that won't heal
- ☐ Dry skin
- ☐ None

Neurological:
- ☐ Headaches
- ☐ Seizures
- ☐ Poor coordination
- ☐ Weakness of arms or legs
- ☐ Paralysis
- ☐ Tremor
- ☐ Numbness in arms or legs
- ☐ Dizziness
- ☐ None

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Trouble sleeping/insomnia
- ☐ Memory loss
- ☐ Confusion
- ☐ None

Endocrine:
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive sweating
- ☐ Increased thirst
- ☐ None

Breasts:
- ☐ Breast mass
- ☐ Breast tenderness
- ☐ Nipple discharge
- ☐ Breast skin changes
- ☐ None

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Immunotherapy

What is Immunotherapy and How Does it Work?

Immunotherapy is a type of cancer treatment that works with your body's own immune system to kill cancer cells. This type of treatment may be given alone or with other cancer treatments.

Examples of immunotherapy include:

atezolizumab (Tecentriq)
avelumab (Bavencio)
cemiplimab (Libtayo)
durvalumab (Imfinzi)
ipilimumab (Yervoy)
nivolumab (Opdivo)
pembrolizumab (Keytruda)

Common Side Effects of Immunotherapy

You may not experience any side effects or just a few side effects. The most common side effects from immunotherapy are:

- Constipation
- Cough
- Decreased appetite
- Diarrhea
- Fatigue or feeling tired
- Fever
- Infusion reaction – shortness of breath, dizziness, rash, fever, chills, and/or pain
- Itching
- Nausea
- Pain in the abdomen, muscles, bones or joints
- Rash

Serious Side Effects of Immunotherapy

Immunotherapy can cause your immune system to attack normal organs and tissues in any area of your body. These problems can sometimes become severe or life-threatening, and may occur anytime during treatment or even after your treatment has ended. If you experience any of the following side effects please **call 479-587-1700.**

Colon/intestinal problems (Colitis)

- Diarrhea or more bowel movements than usual. Diarrhea caused by immunotherapy will not respond to over-the-counter medications such as Imodium. **Call the clinic for a prescription 479-587-1700.**
- Pain or tenderness in your abdomen
- Stools that are black or tarry, or have blood or mucus

Lung problems (Pneumonitis)

- New or worsening cough
- Pain in your chest
- Shortness of breath

Liver problems (Hepatitis)

- Bleeding or bruising more easily
- Dark urine
- Loss of appetite
- Nausea or vomiting
- Pain in the upper right side of you abdomen
- Yellow skin or whites of your eyes

Kidney problems

- Decrease in your amount of urine

Other problems

- Dizziness or fainting
- Feeling more thirsty or hungry
- Headache that will not go away
- Increased heart rate
- Increased sweating
- Infection
- Urinating more frequently
- Weight loss or weight gain

If you go to the emergency room for any reason, please tell the doctor you are currently receiving immunotherapy.

Highlands Oncology Group

Informed Consent for Treatment

I, the undersigned, hereby authorize Dr ________________________ and other members of the healthcare team to treat me for my disease. The purpose, potential benefits, and risks of my treatment, as well as the likelihood of success, alternative methods of treatment, and the possible result of non-treatment has been explained to me. I understand the explanation and have had the opportunity to ask questions and my questions have been answered to my satisfaction.

I understand that if I receive medications, the purpose of these medicines is for the treatment of my cancer. I have received explanation of the medicines and how these medicines are given (administered), as well as any possible side effects. I accept the treatment program and method of medication administration proposed to me.

Some of the more common side effects of these medications may include, but are not limited to:

- nausea and vomiting
- diarrhea
- anemia (low red blood cell count)
- neutropenia (low white blood cell count) with or without fever
- infection
- hair loss
- mouth sores
- numbness or tingling of the hands and feet
- rash
- allergic reaction
- inflammation of colon or lungs
- damage to my veins and the surrounding tissues, causing changes in their appearance, even when the medication is given properly

Some of the medications may cause drowsiness and may impair my ability to drive or operate equipment. I understand that if I receive a medicine that may cause drowsiness, I am required to have someone drive me home after those treatments.

Adverse reactions to medicines or procedures, if serious, could result in permanent injury or even death. In the event of physical injury, adverse reactions, or side effects resulting from these medications, medical treatment will be provided. The cost of treatment and hospitalization of such adverse reactions or side effects, however, will be my responsibility.

Frequent blood draws may be required when receiving treatment or for monitoring my disease. Blood draws may involve discomfort, a risk of bleeding, bruising, or infection at the needle site.

I understand that I have the right to refuse treatment, and that I have the right to refuse to continue treatment after it has begun. Refusal to receive treatment does not deny me the opportunity for any other medical care. Refusal to receive treatment does not deny me the opportunity to reconsider treatment in the future, should I wish to receive treatment at a later time.

My signature indicates that I have read and understand this form, and that I wish to proceed with the treatment as proposed.

______________________________________ ____________________

Patient Signature (or person authorized to consent for patient, or parent if patient is under the age of 18.) Date

____

Patient Name - Printed

____

Witness Signature

Updated 01/2018