WVU Cancer Institute
REGIONAL CANCER CENTER

Affix Patient Label here

2000 Foundation Way, Suite 2600
Martinsburg, WV 25401
Phone: 304-267-1944 Fax: 304-264-1342

Medical History Form

Personal Medical History:

(If answering yes, please provide an estimated date of diagnosis- or at minimum the year you were diagnosed)

Diagnosis	Yes	No
Asthma		
Bleeding Disorder		
Blood Clots		
Cancer (Not otherwise listed)		
CHF (Congestive Heart Failure)		
Colon Cancer		
COPD		
Depression		
Diabetes Type I		
Diabetes Type II		
Hyperlipidemia		
Hypertension		
Hypothyroidism		
Liver Disease		
Lung Cancer		
Heart Attack (Myocardial Infarction)		
Pancreatitis		
Prostate Cancer		
Weight loss, unintentional		
Atrial Fibrillation		
TIA (Transient Ischemic Attack)		
Coronary Artery Disease (CAD)		
Other		

Personal Surgical History:

(If answering yes, please provide an estimated date- or at minimum, a year of procedure)

Surgery	Yes	No
Appendectomy		
Colectomy, partial		
Colectomy, total		
Colonoscopy		
Coronary angioplasty/ stent placement		
Coronary bypass		
Cholecystectomy (Gall Bladder removed/ surgery)		
Joint Replacement- Hip If yes, please circle one of the following: Left or Right		
Joint Replacement- Knee If yes, please circle one of the following: Left or Right		
Kidney Surgery		
Mastectomy, Radical		
Mastectomy, Simple If yes, please circle one of the following: Left or Right		
Prostatectomy (Prostate Removal)		
Tonsillectomy		
Tunneled Cath		
Whipple		
Other		

Family History

- ❑ No Known Problems
- ❑ Family History Unknown

Diagnosis	Family Member	Age at diagnosis
Alzheimer's/ Dementia		
Anesthesia Complications		
Asthma		
Blood Clots		
Breast Cancer		
Colon Cancer		
Leukemia		
Lung Cancer		
Lymphoma		
Melanoma		
Prostate Cancer		
Cancer (not otherwise listed)		
Congestive Heart Failure		
Coronary Artery Disease		
Depression		
Diabetes		
Heart Attack		
Clotting Disorder		
High Cholesterol		
High Blood Pressure (Hypertension)		
Stroke		
Thyroid Disease		
Peripheral Vascular Disease		
Non- Melanoma Skin Cancer		
Fibromyalgia		
Cerebral Aneurysm		

Tobacco History

- ☐ Never Smoker

- ☐ Current Smoker
  - ☐ Every Day Smoker
  - ☐ Heavy Smoker
  - ☐ Light Smoker
  - ☐ Some Day Smoker

  Age/ Year you started smoking: ___________

  - ☐ Cigarettes (_________ Packs/day)
  - ☐ Pipe
  - ☐ Cigars

- ☐ Former Smoker

  Age/ Year you started smoking: ___________

  Age/ Year you quit smoking: ___________

  - Cigarettes (_________ Packs/day)
  - Pipe
  - Cigars

Any Smokeless Tobacco Use?

- ☐ Snuff
- ☐ Chew
  - ☐ Former user
  - ☐ Current User
  - ☐ Never Used

E- Cigarettes/ Vaping

- ☐ Current User Age/ Year Started: ___________
  - ☐ Every Day
  - ☐ Some Day
- ☐ Former User Age/Year Quit: ___________
- ☐ Never Used

Alcohol History

Any Alcohol use?

- ☐ Current
- ☐ Former
- ☐ Never

What do you drink?

- ☐ Beer
- ☐ Wine
- ☐ Liquor

How often do you an alcoholic drink?

- ☐ Monthly or less
- ☐ 2-4 times a month
- ☐ 2-3 times a week
- ☐ 4 or more times a week

How many drinks do you have at a time?

- ☐ 1-2
- ☐ 3-4
- ☐ 5-6
- ☐ 7-9
- ☐ 10 or more

Substance Use History

Any history of substance abuse, including illegal or street drugs?

- ☐ Yes
- ☐ No
- ☐ If yes, please write in type of drug:

  ____

  - ☐ Drug use quit date: ___________

Sexual Activity

Are you sexually active?

- ☐ Yes
- ☐ No

Birth control or protection use?

- ☐ Yes
- ☐ No
- ☐ If yes, please write what type?

  ____

Evaluation of Resources

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

- ❑ Not Hard at all
- ❑ Not very hard
- ❑ Somewhat hard
- ❑ Hard
- ❑ Very hard
- ❑ I decline to answer

Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ❑ Never True
- ❑ Sometimes True
- ❑ Often True
- ❑ I decline to answer

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- ❑ Never True
- ❑ Sometimes True
- ❑ Often True
- ❑ I decline to answer

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

- ❑ Yes
- ❑ No

In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living?

- ❑ Yes
- ❑ No

National Comprehensive Cancer Network®

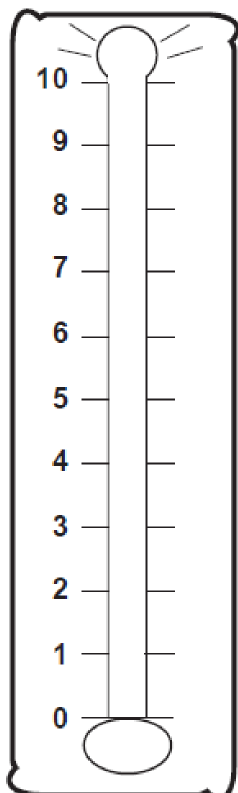
NCCN Distress Thermometer and Problem List for Patients

NCCN DISTRESS THERMOMETER

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress



No distress

PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week including today.
Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Food
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions
		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues
		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	**Spiritual/religious concerns**

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance use
❑	❑	Tingling in hands/feet

Other Problems: ______________________________

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Version 2.2020, 03/11/20. The NCCN Clinical Practice Guidelines (NCCN Guidelines®) are a statement of evidence and consensus of the authors regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult the NCCN Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient's care or treatment. The National Comprehensive Cancer Network® (NCCN®) makes no representations or warranties of any kind regarding their content, use or application and disclaims any responsibility for their application or use in any way. The NCCN Guidelines are copyrighted by National Comprehensive Cancer Network®. All rights reserved. The NCCN Guidelines and the illustrations herein may not be reproduced in any form without the express written permission of NCCN. ©2020.