RIVERSIDE HEALTHCARE

Riverside Cancer Institute Initial Assessment

Date: _____

Name (First, Middle, Last): _____

Date of Birth: _____ Gender: M_____ F_____

Primary Care Provider: _____

Allergies: _____

Medical History (Please Check all that Apply; if Possible, Please Provide Date of Diagnosis)

Heart	Diabetes
Lung	Blood Disorder
Liver	Seizure Disorder
Kidney	Anxiety/ Depression
Thyroid	Hepatitis
Digestive	Tuberculosis
Reproductive	Cancer
Other	

Surgical/ Procedure History (If Possible, Please Provide Date of Surgery/ Procedure.)

_____

_____

_____

_____

_____

_____

Last Colonoscopy: _____ Last Bone Density/ Dexa Scan: _____

Vaccines: _____

History of Blood Transfusions? Yes _____ No_____

If Yes, Have You Ever Had a Transfusion Reaction? Yes_____ No_____

Recent Weight Changes? Yes_____ No_____ Loss_____ Gain_____

Number of Pounds_____ Over What Period of Time? _____

Gynecologic History

Age 1st Period: _____

Last Menstrual Period: _____

Menstrual Cycle Length: _____

Age at Menopause: _____

Reason: _____

Age at 1st Child Birth: _____

Number of Pregnancies: _____

Number of Deliveries: _____

Number of Interrupted Pregnancies: _____

Hormone Use? Yes_____ No_____

Type of Hormone? _____

Number of Years Used: _____

Birth Control Use? Yes _____ No_____

Type of Birth Control? _____

Number of Years Used: _____

Last Mammogram: _____

Last PAP: _____

Family History

Relative	Living/ Deceased	Age/ Deceased Age	Significant Medical History
Father			
Mother			
Brother(s)			
Sister(s)			
Daughter(s)			
Son(s)			

Family History of Cancer: Yes_____ No_____ Relation/ Type: _____

_____

_____

Please Provide Any Other Pertinent Information You Wish to Share with the Doctor: _____

_____

_____

_____

_____

Social History

Marital Status? _____ Who Do You Live with? _____

Occupation? _____

Diet Restrictions? Yes_____ No_____ If Yes, Please Explain_____

Exercise/ Activity Level? _____

Current Smoker: Yes_____ No_____

Packs per Day: _____

Age when Started: _____

Former Smoker: Yes_____ No_____

Age when Started: _____

Date Quit: _____

Packs per Day: _____

Alcohol Use: Yes_____ No_____

Days per Week: _____

Drinks per Day: _____

Illicit Drug Use: Yes_____ No_____

Type: _____

Frequency: _____

Exposure to Hazardous Materials? Yes_____ No_____

If Yes, what Material? _____

Do You Have Adequate Support Systems at Home? Yes_____ No_____

Do You Have Adequate Transportation? Yes_____ No_____

Are You Claustrophobic? Yes_____ No_____