West Michigan Cancer Center
& INSTITUTE FOR BLOOD DISORDERS
A Borgess Bronson Collaboration

WMCC #_____

200 North Park Street
Kalamazoo, MI 49007-3731
Phone: 269.382.2500 / Fax: 269.373.7478
www.wmcc.org

## ADMINISTRATIVE

# HEALTH HISTORY QUESTIONNAIRE

Today's Date:_____ Attending Physician (Office Use) _____

**Individual completing this form** (Relationship to patient) _____

**GENERAL INFORMATION**

Patient Full Name:_____ Social Security #:_____ Date of Birth:_____ Age: ____

Emergency Contact Name / Relationship: _____ Phone: _____

Family Physician:_____ Referring Physician: _____

Other Physicians: _____

Type of Insurance:_____

Primary Insurance Holder Name / Relationship (You / Spouse/ etc): _____

Insurance Holder: Social Security #:_____ Date of Birth:_____

Do you have a Durable Power of Attorney for Health Care/Appointment of a Patient Advocate? ☐ Y ☐ N

If yes, did you bring a copy with you? ☐ Y ☐ N Court Ordered Legal Guardian? ☐ Y ☐ N

Email address: _____ Hospital Preference (labs, scans, admissions): ☐ Borgess ☐ Bronson

**Educational Level:**

☐ Less than High School ☐ High School / GED ☐ Some College
☐ 2 yr College Degree ☐ 4 yr College Degree ☐ Master's Degree
☐ Doctoral Degree ☐ Professional Degree (MD, JD)

Can you read? ☐ Y ☐ N Can you write? ☐ Y ☐ N

Primary Language? _____ Will you need a free translator? ☐ Y ☐ N

Will you be bringing your own translator with you? ☐ Y ☐ N

**Marital Status**

☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated ☐ Single

Adopted ☐ Y ☐ N If yes, history known? ☐ Y ☐ N

Twin? ☐ Y ☐ N If yes: ☐ Identical ☐ Fraternal

**Race:**

☐ Black / African American ☐ Pacific Islander / Hawaiian Native ☐ Other_____
☐ American Indian / Alaskan ☐ White / Caucasian ☐ Do not wish to provide
☐ Asian ☐ Unknown

**Ethnicity:**

☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown
☐ Do not wish to provide ☐ Other_____

Y=Yes N=No

WMCC #_____

**ALLERGIES**

Are there medications or other substances (including food) you are allergic to or cannot take? ☐Y ☐N
Please list these substances and any reaction you had:

_____

_____

_____

**ARE YOU ALLERGIC TO LATEX?** ☐Y ☐N

**CURRENT MEDICATIONS**

Pharmacy of Choice: _____ Phone: _____

Please list all current medications (including over-the-counter drugs, such as aspirin, sinus tablets, laxatives, vitamins, herbs, nutritional supplements, etc.) List anything that you purchase at a natural health store.
If more space is required, please attach a separate list.

It is vital that we have all of the information below—if it would be easier for you, bring your medication bottles with you to your appointment. We will be able to get the information from your bottles.

Please note we have a controlled substance (such as pain med, anti-depression/anxiety) policy at WMCC. If at any time one of our providers prescribes a controlled substance, you will be asked to sign a contract.

| Name of Drug | Date Started | Prescribing Doctor | Dose | Frequency |
|---|---|---|---|---|
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Y=Yes N=No

**PAST MEDICAL HISTORY**

WMCC #_____

Has a doctor ever told you that you have any of the following conditions?
Check Yes or No for each condition.

**Cancer / Treatment for cancer**

Previous cancer ☐Y ☐N
Type _____
Radiation therapy ☐Y ☐N
Chemotherapy ☐Y ☐N
Hormone therapy for cancer ☐Y ☐N
Radiation for non cancer ☐Y ☐N

**Cardiovascular**

High blood pressure ☐Y ☐N
Heart murmur ☐Y ☐N
Stroke ☐Y ☐N
Rheumatic Fever ☐Y ☐N
Angina ☐Y ☐N
Heart attack ☐Y ☐N
Heart failure ☐Y ☐N
Irregular Rhythm ☐Y ☐N

**Eyes**

Cataracts ☐Y ☐N
Glaucoma ☐Y ☐N

**Ear/Nose/Throat/Mouth**

Goiter of thyroid ☐Y ☐N
Hearing Difficulty ☐Y ☐N

**Respiratory**

Asthma ☐Y ☐N
Chronic bronchitis ☐Y ☐N
Emphysema ☐Y ☐N
Tuberculosis ☐Y ☐N

**Endocrine**

Diabetes ☐Y ☐N
Hyperthyroidism ☐Y ☐N
Hypothyroidism ☐Y ☐N

**Skin**

Scleroderma ☐Y ☐N
Psoriasis ☐Y ☐N

**Gastrointestinal**

Crohn's disease (enteritis) ☐Y ☐N
Ulcerative colitis ☐Y ☐N
____# Polyps in rectum/ colon
Hernia ☐Y ☐N
Intestinal bleeding ☐Y ☐N
Ulcer ☐Y ☐N
Gallstones ☐Y ☐N
Jaundice/ Hepatitis ☐Y ☐N
Cirrhosis of liver ☐Y ☐N
Pancreatitis ☐Y ☐N
Spastic colon/Irritable colon ☐Y ☐N

**Genitourinary**

Kidney stones ☐Y ☐N
Bladder leakage ☐Y ☐N
Bladder prolapse ☐Y ☐N
MEN-Prostate problems ☐Y ☐N

**Blood Diseases**

Collagen vascular disease ☐Y ☐N
Anemia ☐Y ☐N
Stroke ☐Y ☐N
Other blood disorders ☐Y ☐N
Blood Clots in legs or lungs (DVT/PE) ☐Y ☐N

**Musculoskeletal**

Osteoarthritis ☐Y ☐N
Rheumatoid arthritis ☐Y ☐N
Gout ☐Y ☐N
Osteoporosis ☐Y ☐N

**Other**

Lupus ☐Y ☐N
Metal fragment in your body ☐Y ☐N
If yes, Where? _____
HIV Positive (AIDS)? ☐Y ☐N
_____
_____
_____

| Screenings: Month / Year of last: | Where Done? | By Whom? | Abnormal? |
|---|---|---|---|
| Colonoscopy | | | ☐Y ☐N |
| Mammogram | | | ☐Y ☐N |
| Pap Smear | | | ☐Y ☐N |

Y=Yes N=No

WMCC #_____

| PAST SURGICAL HISTORY | YES / NO | Age | Hospital / City-Surgery Performed |
|---|---|---|---|
| Cataract Surgery: ☐ L ☐ R | ☐ Y ☐ N | | |
| Heart: Coronary Artery Bypass | ☐ Y ☐ N | | |
| Heart Stent / Replacement | ☐ Y ☐ N | | |
| Heart Valve Replacement | ☐ Y ☐ N | | |
| Pacemaker | ☐ Y ☐ N | | |
| Serial # Model # | | | |
| Hip/Knee Replacement: ☐ L ☐ R | ☐ Y ☐ N | | |
| Gall Bladder | ☐ Y ☐ N | | |
| Tonsils | ☐ Y ☐ N | | |
| Appendix | ☐ Y ☐ N | | |

| | YES / NO | Age | Hospital / City-Surgery Performed |
|---|---|---|---|
| **MEN** | | | |
| Prostate Surgery | ☐ Y ☐ N | | |
| Vasectomy | ☐ Y ☐ N | | |
| **WOMEN** | | | |
| Breast Biopsy ☐ L ☐ R | ☐ Y ☐ N | | |
| Breast Removal (Mastectomy) ☐ L ☐ R | ☐ Y ☐ N | | |
| Lumpectomy ☐ L ☐ R | ☐ Y ☐ N | | |
| Tubal Ligation | ☐ Y ☐ N | | |
| Hysterectomy | ☐ Y ☐ N | | |
| Ovary Removal ☐ L ☐ R | ☐ Y ☐ N | | |

| List all other surgeries | Age | Hospital / City-Surgery Performed |
|---|---|---|
| | | |
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| OB-GYN HISTORY | | | |
|---|---|---|---|
| At what age did you have your first period? | | Have you been diagnosed with endometriosis? | ☐ Y ☐ N |
| How many pregnancies have you had? | | Have you ever been diagnosed with fibroids? | ☐ Y ☐ N |
| How many babies have you delivered? | | Have you ever had an abnormal pap smear? | ☐ Y ☐ N |
| How many vaginal deliveries? | | Have you ever taken birth control pills? | ☐ Y ☐ N |
| How many c-sections? | | How many years? | |
| How many miscarriages / abortions? | | Have you ever used hormone replacement therapy? | ☐ Y ☐ N |
| At what age did you go through menopause? | | How many years? | |

Y=Yes N=No

## SEXUAL HEALTH

WMCC #_____

**Do you have any questions or concerns regarding fertility?** ☐ Y ☐ N
Treatment may impact your child bearing health – Please discuss with your WMCC physician.

**Do you have any questions or concerns regarding sexual activity?** ☐ Y ☐ N
Treatment may impact your sexual activity – Please discuss with your WMCC physician.

**Over the past three months, how sexually satisfied do you feel overall?** (Check one)

☐ Very ☐ Somewhat ☐ Neutral ☐ Not Satisfied ☐ No Comment

Are you concerned with your sexual health? ☐ Y ☐ N ☐ Prefer not to answer
Are you experiencing vaginal dryness/pain? ☐ Y ☐ N ☐ Prefer not to answer
Are you experiencing erectile dysfunction? ☐ Y ☐ N ☐ Prefer not to answer

Respecting your comfort and emotional health is an extremely important part of your care.
If you have experienced a sexual trauma in the past, please inform physician or clinical support staff.

## SOCIAL HISTORY

Currently Working? ☐Y ☐N Occupation: _____
Retired? ☐Y ☐N Prior Occupation: _____
Disabled? ☐Y ☐N
Disability:_____
Live in: ☐ Home ☐ Apartment ☐ Heath Care Facility ☐ Staying with family / friends ☐ Homeless
Live with:_____

**Recreational Drugs**
☐ Never used
☐ Not currently using.
When did you stop? _____
☐ Marijuana _____joints/week _____ years
☐ Cocaine _____snorts/week _____ years
☐ Other: _____
_____

**Alcohol**
☐ Never used
☐ Not currently using.
When did you stop? _____
☐ Beer _____ bottles/week _____ years
☐ Wine _____ glasses/ week _____ years
☐ Liquor _____ shots/ week _____ years
Rehabilitation / Alcoholics Anonymous (AA) ☐Y ☐N

**Smoking / Tobacco Use**
☐ Never smoked
☐ Not currently smoking
When did you stop? _____
☐ Currently Smoking
Have you tried to quit? ☐Y ☐N
If yes, what did you try? _____
☐ Cigarettes _____ #pks/week _____ years
☐ Cigars _____ #/week _____ years
☐ Pipe _____ # bowls/week _____ years
☐ Snuff _____ #/week _____ years
☐ Chewing _____ #/week _____ years
☐ Marijuana _____ # joints/week _____ years
☐ I have a medical marijuana card

WMCC #_____

**REVIEW OF SYSTEMS**

Do you now or have you had any problems within the last 6 months related to the following systems?
Check Y (YES) or N (No) for each symptom.

**Gastrointestinal**

| | | |
|---|---|---|
| Abdominal pain | ☐Y | ☐N |
| Nausea | ☐Y | ☐N |
| Vomiting | ☐Y | ☐N |
| Indigestion | ☐Y | ☐N |
| Heartburn | ☐Y | ☐N |
| Diarrhea | ☐Y | ☐N |
| Constipation | ☐Y | ☐N |
| Dark stools | ☐Y | ☐N |
| Bright red bleeding | ☐Y | ☐N |
| Problems chewing | ☐Y | ☐N |
| Swallowing | ☐Y | ☐N |

**Hematologic / Lymphatic**

| | | |
|---|---|---|
| Swollen glands | ☐Y | ☐N |
| Blood clotting problems | ☐Y | ☐N |

**Eyes**

| | | |
|---|---|---|
| Blurred vision | ☐Y | ☐N |
| Double vision | ☐Y | ☐N |
| Pain | ☐Y | ☐N |

**Ear/Nose/Throat/Mouth**

| | | |
|---|---|---|
| Ear infection | ☐Y | ☐N |
| Sore throat | ☐Y | ☐N |
| Sinus problems | ☐Y | ☐N |
| Loss of smell | ☐Y | ☐N |
| Ringing in ears | ☐Y | ☐N |

**Endocrine**

| | | |
|---|---|---|
| Excessive thirst | ☐Y | ☐N |
| ☐Too hot / ☐Cold | ☐Y | ☐N |
| ☐Tired / ☐Sluggish | ☐Y | ☐N |

**Respiratory**

| | | |
|---|---|---|
| Wheezing | ☐Y | ☐N |
| Frequent cough | ☐Y | ☐N |
| Shortness of breath | ☐Y | ☐N |
| Coughing up of blood | ☐Y | ☐N |
| Hay fever | ☐Y | ☐N |

**Cardiovascular**

| | | |
|---|---|---|
| Chest pain | ☐Y | ☐N |
| Varicose veins | ☐Y | ☐N |

**Constitutional Symptoms**

| | | | |
|---|---|---|---|
| Fever | ☐Y | ☐N | |
| Chills | ☐Y | ☐N | |
| Headache | ☐Y | ☐N | |
| Night sweats | ☐Y | ☐N | |
| Hot flashes | ☐Y | ☐N | |
| Loss of appetite | ☐Y | ☐N | |
| Loss of taste | ☐Y | ☐N | |
| Recent weight loss | ☐Y | ☐N | _____ #lbs |
| Recent weight gain | ☐Y | ☐N | _____ #lbs |

How much water do you drink in a day? _____

Other: _____

**Musculoskeletal**

| | | |
|---|---|---|
| Change in height | ☐Y | ☐N |
| Joint pain | ☐Y | ☐N |
| Neck pain | ☐Y | ☐N |
| Back pain | ☐Y | ☐N |

**Neurological**

| | | |
|---|---|---|
| Tremors | ☐Y | ☐N |
| Dizzy spells | ☐Y | ☐N |
| Numbness / tingling | ☐Y | ☐N |
| Location _____ | | |
| Memory changes | ☐Y | ☐N |

**Skin**

| | | |
|---|---|---|
| Skin rash | ☐Y | ☐N |
| Boils | ☐Y | ☐N |
| Persistent itch | ☐Y | ☐N |

**Genitourinary**

| | | |
|---|---|---|
| Not able to urinate | ☐Y | ☐N |
| Pain when urinating | ☐Y | ☐N |
| Urinating frequently | ☐Y | ☐N |
| Urinate at night | ☐Y | ☐N |
| # of times _____ | | |

**Psychologic**

| | | |
|---|---|---|
| Are you happy with your life? | ☐Y | ☐N |
| Do you feel severely depressed? | ☐Y | ☐N |
| Have you considered harming yourself? | ☐Y | ☐N |
| Have you ever been on or are you currently taking anti-depressants / anxiety medications? | ☐Y | ☐N |
| Have you been hospitalized for any psychiatric /mental health reason? | ☐Y | ☐N |

Y=Yes N=No

WMCC #_____

**FAMILY HISTORY**

How many children do you have? ____ daughters ____ sons

How many siblings do you have? ____ brothers ____ sisters

How many siblings does/did your mother have? ____ brothers ____ sisters

How many siblings does/did your father have? ____ brothers ____ sisters

Are you of Ashkenazi Jewish descent? ☐ Y ☐ N

Has anyone in your family had cancer? ☐ Y ☐ N

If yes: Please fill out the table below. Be sure to tell us if anyone has had more than one type of cancer.

| Relationship (e.g. mother, father, etc.) | M / F | Check One | | Type(s) of Cancer | Age at diagnosis | Fill in one column | |
|---|---|---|---|---|---|---|---|
| | | Father's Side | Mother's Side | | | Current Age | If deceased, **age** at death |
| 1. | | ☐ | ☐ | | | | |
| 2. | | ☐ | ☐ | | | | |
| 3. | | ☐ | ☐ | | | | |
| 4. | | ☐ | ☐ | | | | |
| 5. | | ☐ | ☐ | | | | |
| 6. | | ☐ | ☐ | | | | |
| 7. | | ☐ | ☐ | | | | |
| 8. | | ☐ | ☐ | | | | |
| 9. | | ☐ | ☐ | | | | |
| 10. | | ☐ | ☐ | | | | |

Did anyone in your family die before age 40? ☐ Y ☐ N

If yes: Please fill out the table below.

| Relation of the deceased (e.g. father's sister) | Age at death | Cause of death |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

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WMCC # _____

# ADMINISTRATIVE

## WMCC REQUEST / AUTHORIZATION FOR THE RELEASE OF HEALTH CARE INFORMATION

I authorize ***West Michigan Cancer Center & Institute for Blood Disorders*** to release verbally or in print of the following healthcare information regarding:

_____ _____
(Patient's Name – Please Print) (Patient's Date of Birth)

**Records relating to visit(s) / service(s) of:** _____
**(Specific dates or services, or can list "ALL")**

**Purpose of disclosure:** (i.e. individual's request, insurance, continuing care) _____

This authorization will expire: ☐ Indefinitely ☐ Specific Date: _____

Information to be released:

- ☐ Consultation(s) & Follow-ups
- ☐ Appointment Time/Location
- ☐ WMCC Images on a Disc
- ☐ Laboratory Report(s) & Pathology
- ☐ Printed Radiology Reports (CT/MRI)
- ☐ Insurance & Disability Forms
- ☐ Billing & Payment Information
- ☐ Support Services (Nursing, Nutrition)
- ☐ Consents
- ☐ Prescriptions & Medications
- ☐ Correspondence
- ☐ Genetic Records
- ☐ Operative Report
- ☐ Health History Questionnaire
- ☐ Education Documents
- ☐ Other _____

In order to protect our patients, **specific authorization is required** to release certain information. If any of the following apply, and you wish to have that information released, you must place your initials on the line next to the appropriate line:

- _____ Treatment of emotional illness, including documentation by a social worker, psychologist/psychiatrist (**does not** include psychotherapy notes)
- _____ Treatment of alcohol or substance abuse
- _____ Results of HIV testing; treatment of HIV infection, AIDS or AIDS-related complex
- _____ Treatment of venereal disease, tuberculosis or communicable disease as specified by the MI Department of Public Health

**Information is to be released to:**

| Name | Relationship | Phone Number |
|---|---|---|
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This authorization may be revoked at any time by notifying the organization in writing at WMCC, Privacy Officer, 200 N. Park St, Kalamazoo, MI 49007, but this will not affect disclosures made prior to receipt of the revocation.

I understand this authorization is voluntary and any treatment I may seek will not be conditioned upon my signing this authorization. Applicable federal and state laws protect information used or disclosed pursuant to this authorization. Information released may be subject to redisclosure by the recipient and will no longer be protected by the HIPAA Privacy Rule.

By signing this Authorization, I acknowledge I have read it and I understand it.

**Signed:** _____ _____
(Patient or Authorized Representative) (Date)

**Description of Authorized Representative's Authority to Sign:** _____

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# SOCIAL SERVICES

## NEEDS INTAKE ASSESSMENT: PSYCHOSOCIAL STRESS SCREENING

In compliance with The American College of Surgeon's Commission on Cancer, the West Michigan Cancer Center & Institute for Blood Disorders (WMCC) provides you with free services regarding coping with illness and the changes it can bring to you and your family. This form will be reviewed by your physician and a social worker to coordinate appropriate services for quality care. ***Please print clearly to ensure timely response to your needs.***

Today's Date:_____ Name: _____ Date of birth: _____

Address: _____

Phone: _____ Who is filling out this form (and relationship): _____

WMCC Physician:_____ Were you in the military and honorably discharged? ☐ Y ☐ N When?_____

Do you have a medical advocate? This is someone you requested to make medical decisions if/when you cannot communicate your wishes; and is called a Durable Power of Attorney for Medical Care. ☐ Y ☐ N if no, would you like information? ☐ Y ☐ N

Has a judge ordered another adult to help you make legal decisions? (legal guardian)? ☐ Y ☐ N If yes, name:_____

What is your understanding of your appointment at WMCC today? _____

_____

What is your highest level of completed education: _____ Primary language: _____

***Stress Scale***: Many people find doctor's appointments stressful. On a scale of one to ten, with ten being the worst amount of stress, and zero being the least amount of stress, please circle your level of stress today.

0 1 2 3 4 5 6 7 8 9 10

**Low stress** **Medium stress** **High stress**

Are you a parent concerned about discussing your diagnosis with your under-aged children? ☐ Y ☐ N

**Check all of the areas below that contribute to your stress and that you are currently experiencing:**

| Currently having issues with meeting basic needs | Currently experiencing | Do you have a history of mental health issues |
|---|---|---|
| ☐ Housing Crisis<br>☐ Financial Distress<br>☐ Insurance<br>☐ Transportation Limitations<br>☐ Employment<br>☐ Family Relationships<br>☐ Abuse or Neglect<br>Do you feel safe at home?<br>☐ Y ☐ N<br><br>(**Please note**: If you indicate you ***do not feel safe at home***, clinicians reviewing this form are mandated reporters and required by law to call you to discuss safety.) | ☐ Fear<br>☐ Anxiety<br>☐ Sadness<br>☐ Worry<br>☐ Anger<br>☐ Spiritual concerns<br>☐ Increase in substance use<br>☐ Other:<br>_____<br><br>Are you currently being treated for a mental health condition?<br><br>_____<br><br>By whom?_____ | ☐ Clinical Depression<br>☐ Clinical Anxiety<br>☐ Substance use/addiction<br>☐ Past psychiatric hospitalization<br>☐ Family history of mental health issues<br>☐ Past thoughts or attempts of self harm<br>☐ Currently seeing a counselor/psychiatrist<br>☐ Currently on mental health medication?<br><br>☐ Other: _____ |

As part of your care team, WMCC has clinical social workers specialized in blood disorders and cancer care. Would you like a clinical social worker to contact you for follow up for resources and support for issues noted above: ☐ Y ☐ N

➢ ***WMCC Staff Processing: Original document to physician, copy to social work.*** ➣

Y=Yes N=No

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# NUTRITION

## NUTRITION SCREENING FORM

Name: _____ Date of Birth: _____

In compliance with The American College of Surgeon's Commission on Cancer, the West Michigan Cancer Center (WMCC) provides you with free services regarding information on nutrition and diet changes through treatment. This form will be reviewed by your physician and a registered dietitian to coordinate appropriate services for quality care.
***Please print clearly to ensure timely response to your needs.***

Height: _____

Weight: _____

Have you had recent unintentional weight loss in the past month? ☐ Y ☐ N

If yes, how much? _____

Have you had any recent unintentional weight loss in the past six months? ☐ Y ☐ N

If yes, how much? _____

Have you experienced any of the following problems in the past month?

1. Vomiting lasting more than three days? ☐ Y ☐ N
2. Diarrhea (more than three liquid stools per day)? ☐ Y ☐ N
3. Loss of appetite or nausea? ☐ Y ☐ N
4. Difficulty or pain with chewing or swallowing? ☐ Y ☐ N

Do you currently have a feeding tube? ☐ Y ☐ N

If yes, for how long? _____

Who do you receive your supplies from? _____

Are you currently receiving TPN (nutrition through your vein)? ☐ Y ☐ N

If yes, for how long? _____

Who do you receive your supplies from? _____

➢ ***WMCC Staff Processing: Original document to physician, copy to registered dietitian.*** ➢

PRINT

Y=Yes N=No