

Prostate Cancer Treatment Center New Patient Questionnaire

Name: _____ Today's date: _____

MEDICAL HISTORY

Previous cancer Y / N Stroke Y / N Crohn's disease or Ulcerative colitis Y / N
High blood pressure Y / N Emphysema/COPD Y / N Kidney loss, dysfunction or abnormality Y / N
Heart attack Y / N Diabetes Y / N Lupus/Scleroderma/Collagen vascular disease Y / N
Pacemaker Y / N Diverticulitis Y / N Rheumatoid/Psoriatic Arthritis Y / N

Previous radiation therapy Y / N If yes, to what part of the body? _____
Facility name _____ Dates: _____

Previous or current chemotherapy Y / N If yes, facility name _____
Dates: _____

Previous surgeries:

Type of Operation Approximate Date Type of Operation Approximate Date

Other illnesses/hospitalizations _____
Prostate Surgery (Transurethral resection of prostate "TURP") Y/N If yes, when? _____
Date of last colonoscopy _____

MEDICATIONS/SUPPLEMENTS (List **ALL** medications/vitamins & supplements you are currently taking)

Medication Dose Dose/day Medication Dose Dose/day

MEDICATION ALLERGIES

_____ None
Medication _____ Reaction _____
Medication _____ Reaction _____

FAMILY HISTORY OF CANCER

Type/location of cancer Age at diagnosis Type/location of cancer Age at diagnosis
Father _____ Brother/sister _____
Mother _____ Brother/sister _____

SOCIAL HISTORY

Do you drink alcohol Y / N If yes, average number of drinks per day _____
Have you ever smoked cigarettes Y / N If yes, year you began smoking _____ Year stopped _____
Average # of packs smoked per day _____ List other tobacco products used _____

Current occupation _____ # years _____
Previous occupation _____ # years _____

REVIEW OF SYSTEMS Have you developed any of these symptoms in the past year?

Weight loss Y / N Fatigue Y / N Cough Y / N Weakness Y / N
Decreased appetite Y / N Fever Y / N Short of breath Y / N Numbness/Tingling Y / N
Nausea Y / N Bone pain Y / N Chest pain Y / N Memory problems Y / N
Diarrhea Y / N Skin rashes Y / N Depression Y / N Vision/Hearing changes Y / N
Bleeding problems Y / N Swollen glands Y / N Headaches Y / N Change in urination Y / N