COMPASSIONATE ONCOLOGY
MEDICAL GROUP

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AMERICAN BOARDS OF INTERNAL MEDICINE,
MEDICAL ONCOLOGY AND HEMATOLOGY
Subspecialty of Prostate Cancer

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HEMATOLOGY
AND PROSTATE CANCER

Patient Information

1. First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Male ○ Female

Social Security Number: _____

Birth Place: _____

Address: _____

Apt/Unit Number: _____

Home Phone: _____

Cell Phone: _____

Business Phone: _____

Email: _____

○ Married ○ Never Married
○ Divorced ○ Seperated
○ Domestic Partner ○ Widowed

Spouse/Partner's Name: _____

Spouse/Partner's Phone Number: _____

Race:
○ American Indian or Alaskan Native ○ Asian
○ African American
○ Native Hawaiian or Pacific Islander ○ White

Ethnicity:
○ Hispanic or Latino
○ Not Hispanic or Latino
○ Decline to Answer

Preferred Language:
○ English ○ Other

If other, please specify: _____

Best way to be contacted for appointment reminders:
○ Home Phone ○ Cell Phone ○ Business Phone
○ Other Phone Number ○ Email

If other phone number, please specify: _____

How did you hear about us? _____

Who is authorized to speak to our staff regarding your treatment at COMG/Medical Records? List all persons, relationship to patient & phone numbers.

_____

_____

Do you currently smoke any tobacco products?
○ Yes ○ No ○

Do you have any allergies?
○ Yes ○ No

Do you consent to have prescriptions filled at our Compassionate Oncology Pharmacy?
○ Yes ○ No

Current Local Pharmacy Name: | Pharmacy Phone: | Pharmacy Fax:

Pharmacy Address:

2. Primary Insurance Company:

Your ID #: | Group #:

Insured Name: | Relationship to Patient:

Secondary Insurance Company:

Your ID #: | Group #:

Insured Name: | Relationship to Patient:

Emergency Contact (Not Living With You)

3. Name: | Relationship: | Phone:

Address: | Apt/Unit #:

Secondary Name: | Relationship: | Phone:

Address: | Apt/Unit #:

4. **Do you have any Advanced Directives in place such as a Living Will, Durable Power of Attorney or a Do Not Resuscitate order?**

- ○ Living Will
- ○ Durable Power of Attorney
- ○ Do Not Resuscitate Order
- ○ None of the Above

Physician Information

Please list all Physicians you are seeing, have seen, or would like us to send a copy of our consultation. If additional space is needed, please click on "Add More Rows".

5.

	Physician Name	Address	Phone Number
1			
2			
3			

6. I was referred by:

_____

History of Present Illness

7. Date First Diagnosed: _____ How were you diagnosed? _____

☐ Elevated PSA
☐ Abnormal Prostate
Exam Date: _____
PSA level at time of diagnosis (ng/ml): _____

☐ Biopsy that showed prostate cancer
Date: _____
Gleason: _____

Biopsy done where: _____ Biopsy done by whom: _____

When was your last Bone Scan: _____ When was your last CT Scan: _____ When was your last MRI Scan: _____

8. Post and Current Treatments:

	Test Performed?	Date Started	Date Stopped
Firmagon			
Radiation			
Brachytherapy Seeds			
Hormone Therapy (included with Radiation/Brachytherapy)			
Prostatectomy			
Orchiectomy			
Ketoconazole (Nizoral)			
Lupron, Zoladex or Triptorelin			
Casodex			
DES			
Enzalutamide (Xtandi), Abiraterone (Zytiga) with Prednisone			
Chemotherapy			
No Treatment			
Active Surveillance Only			
Estrodial (Estrogen)			

9. Are you currently symptomatic from your prostate cancer?

- ○ Yes
- ○ No

10. Medical Problems: Please list in order of importance to you

	Problem	When did it start?	Is this an active problem? (Y/N)	Is it currently being treated? (Y/N)
1				
2				
3				

11. Surgical History

	Date	Procedure
1		
2		
3		

12. Current Medications (List prescription and non-prescription):

	Drug Name	Dose	Frequency	Start Date	Reason for Taking
1					
2					
3					

13. Allergies to Medications

	Medication	Reaction
1		
2		
3		

Herbal Supplements/Vitamins

Please use one of the following reasons below as your reason for taking (1-8):

1. Relieve symptoms relating to cancer
2. Relieve symptoms relation to other medical conditions
3. Treatment of cancer
4. Treatment of other condition
5. Prolong life
6. Improve quality of life
7. Strengthen immune system
8. General health

Use one of the following reasons below for How has your intake changed since your diagnosis (1-5):

1. Stopped taking
2. Started taking
3. Increased dose
4. Decreased dose
5. No change

14. Check if you have taken:

	Currently	Previously	Dose	Reason for Taking	How has your intake changed since your diagnosis?
Antioxidant Complex					
Beta Carotene					
Calcium					
Iron					
Magnesium					
Multivitamin Complex					
PC - SPES					
Potassium					
Saw Palmetto					
Selenium					
Vitamin A					
Vitamin B or B Complex					
Vitamin C					
Vitamin D					
Vitamin E					
Vitamin K					
Other:					
None of the Above					

If other, specify:

_____

15. How did you get information on supplement use?

- ☐ Magazine
- ☐ Television
- ☐ Internet
- ☐ Cancer doctor or health professional
- ☐ Other doctor or health professional
- ☐ Friend or family member
- ☐ Other:
- ☐ N/A

If other, specify:

_____

16. Since your diagnosis, have you participated in any alternative therapies? If yes, please check all those that apply:

- ☐ Acupuncture
- ☐ Acupressure
- ☐ Aromatherapy
- ☐ Biofeedback
- ☐ Change in diet
- ☐ Chiropractic
- ☐ Energy healing or Healing touch
- ☐ Exercise
- ☐ Folk remedies
- ☐ Herbal medicine or vitamin therapy
- ☐ Hypnosis
- ☐ Imagery
- ☐ Massage
- ☐ Medication
- ☐ Naturopathy/Natural medicine
- ☐ Self-help group
- ☐ Spirtual healing or prayer
- ☐ Yoga
- ☐ Other:
- ☐ None

If other, specify:

_____

Social History

17. Current Marital Status:

○ Single ○ Married ○ Widowed
○ Divorced/Separated ○ Significant Other

Name of Spouse/Significant Other:

_____

Do you have any children?

○ Yes ○ No

If yes, how many?

_____

What is/was your occupation?

_____

Retired?

○ Yes ○ No

Do you live:

○ Alone ○ Partner only ○ Nuclear Family
○ Extended Family ○ Other

If other, describe:

_____

18. What is your religious affiliation? (leave blank if decline to answer)

_____

19. What is the country of origin of your grandparents (if it is Mexico, specify the State):

	Country	State	If your grandparents are Jewish, are they of Ashkenazl decent? (Y/N)
Father's Father			
Father's Mother			
Mother's Father			
Mother's Mother			

20. Your primary language:
☐ English ☐ Other

If other, please specify:

Are there any cultural/spirtual beliefs that would affect your care or treatment?
○ Yes ○ No

If yes, please explain:

21. Alcohol Consumption: *1 unit = 1 oz of hard alcohol or 8 oz of beer/wine.

	Never/Rarely	Occasional Drinker (1-2 units/month)	Light Drinker (1-15 units/week)	Moderate Drinker (16-42 units/week)	Heavy Drinker (>42 units/week)
Current Pattern					
Past Pattern					

22. Do you currently smoke cigarettes?

○ Yes
○ No

23. Did you smoke cigarettes in the past?

○ Yes
○ No

24. If yes to either question:

How many packs do/did you smoke per day?
☐ 0 ☐ <1 ☐ 1 ☐ Between 1 & 2 ☐ 2
☐ Between 2 & 3 ☐ 3 or more

How many years do/did you smoke?

If previously, how long ago did you quit?

Do you smoke cigars?
☐ Yes ☐ No ☐ Previously

Do you smoke a pipe?
☐ Yes ☐ No ☐ Previously

Do you chew tobacco?
☐ Yes ☐ No ☐ Previously

Nutrition/Exercise:

25. Do you consider your diet to fit any of the following categories? If yes, please select all that apply:

☐ Low fat/Low cholesterol ☐ High protein ☐ Low calorie
☐ Low carbohydrate ☐ Vegetarian/Vegen

26. Do you currently eat soy products, such as edamame beans, tofu or soy milk?
○ Yes ○ No

If yes, how many times per week?

Do you currently drink green tea?
○ Yes ○ No

If yes, how many times per week?

27. **Including time at work and at home, which of the following categories best describes your level of physical activity during the last 12 months:**

○ Inactive (have done hardly any physical work or exercise)

○ Active (have done moderate physical work or leasure activities such as running, cycling, swimming or aerobics for less than 30 minutes per day less than 3 times per week)

○ Very active (have done strenuous physical work or leisure activities for more than 30 minutes per day mor ethan 3 times per week)

Head and Neck

28. **Do you currently wear any of the following?**

☐ Glasses ☐ Contact Lenses ☐ Hearing Aid

29. **Have you had frequent or ongoing problems related to:**

☐ Eye ☐ Ear ☐ Nose
☐ Throat ☐ None ☐ Other:

If other, specify:

Respiratory

30. **Do you have a history of:**

☐ Asthma ☐ Chronic Cough ☐ Shortness of Breath
☐ Emphysmea/COPD ☐ Bronchitis ☐ Allergies
☐ None ☐ Other:

If other, specify:

Hematologic

31. **Have you have frequent or ongoing problems related to:**

☐ Anemia ☐ Hemophilia ☐ Bleeding
☐ None ☐ Other:

If other, specify:

Gastrointestinal

32. Have you have frequent or ongoing problems related to:

- ☐ Indigestion
- ☐ Nausea
- ☐ Vomitting
- ☐ Frequent Bowel Movements
- ☐ Blood in Bowel Movements
- ☐ Pancreatic Disease
- ☐ Liver Disease
- ☐ None
- ☐ Other:

If other, specify:

_____

Urinary

33. Have you have frequent or ongoing problems related to:

- ☐ Loss of Bladder Control
- ☐ Frequency
- ☐ Pain upon Urination
- ☐ Difficulty Starting or Stopping Stream
- ☐ Blood in Urine
- ☐ None
- ☐ Other:

If other, specify:

_____

34. How many times do you urinate at night?

_____

Sexual Function

35. Are you currently sexually active?
○ Yes ○ No

Can you achieve an errection?
○ Yes ○ No

Can you ejaculate?
○ Yes ○ No

Would you like a consult in the area of sexual function?
○ Yes ○ No

Neurological

36. Do you have a history of seizures?
○ Yes ○ No

History of strokes?
○ Yes ○ No

37. Have you had frequent or ongoing problems related to:

- ☐ Fainting spells or Blacking out
- ☐ Headache
- ☐ Numbness/Tingling
- ☐ None
- ☐ Other:

If other, specify:

_____

Pain Assessment

38. Please indicate your pain level today:

_____

Has pain been a problem in your prostate illness
○ Yes ○ No

If yes, does your pain interfere with daily activities?
○ Yes ○ No

Would you like a medical consult in the area of pain management?
○ Yes ○ No

39. How do you deal with your pain?

- ☐ Medication
- ☐ Alternative therapies
- ☐ Nothing
- ☐ Other:

If other, specify:

_____

Skin

40. Have you had frequent or ongoing problems related to:

- ☐ Skin Tumors/Moles removed or burned
- ☐ Skin Sensitivities/Rashes
- ☐ None
- ☐ Other:

If other, specify:

_____

Endocrine

41. Have you had frequent or ongoing problems related to:

- ☐ Diabetes
- ☐ Thyroid
- ☐ Hormone Changes
- ☐ Increased Appetite
- ☐ Excessive thirst or Urination
- ☐ Hot Flashes
- ☐ Breast Enlargement
- ☐ None
- ☐ Other

If other, specify:

_____

Psychiatric

42. Have you ever been depressed?
○ Yes ○ No

Have you ever been treated for depression?
○ Yes ○ No

Have you ever had any other psychiatric diagnosis?
○ Yes ○ No

Have you ever been treated for any other psychiatric diagnosis?
○ Yes ○ No

Musculoskeletal

43. Have you had frequent or ongoing problems related to:

- ☐ Broken bones or fractures
- ☐ Arm or leg weakness
- ☐ Osteoporosis
- ☐ Back pain
- ☐ Arthritis
- ☐ No
- ☐ Other

If other, specify:

_____

Cardiovascular

44. Have you had frequent or ongoing problems related to:

- ☐ Chest pain or Angina
- ☐ High Blood Pressure
- ☐ Leg pain while walking
- ☐ Irregular pulse
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Swelling in feet or hands
- ☐ None
- ☐ Other

If other, specify:

Please List Your Present Physicians

45. Referring Physician

Name: _____ Specialty: _____

Address: _____ Apt/Unit #: _____

Telephone: _____ Fax: _____

☐ Please Send reports to this Physician
☐ Do NOT send reports

46. Primary Physician

Name: _____ Specialty: _____

Address: _____ Apt/Unit #: _____

Telephone: _____ Fax: _____

☐ Please Send reports to this Physician
☐ Do NOT send reports

47. Other Physician

Name: _____ Specialty: _____

Address: _____ Apt/Unit #: _____

Telephone: _____ Fax: _____

☐ Please Send reports to this Physician
☐ Do NOT send reports

48. Other Physician

Name: _____ Specialty: _____

Address: _____ Apt/Unit #: _____

Telephone: _____ Fax: _____

☐ Please Send reports to this Physician
☐ Do NOT send reports

Family History

For relatives, please list (if applicable) as follows: You, your spouse/significant other, mother, father, sisters, brothers, sons, daughters.

Maternal: grandparents, aunts, uncles, cousins
Paternal: Grandparents, aunts, uncles, cousins

49. Have you and your blood relatives ever had any cancer as listen below?

	List relative(s) and age of diagnosis
Bladder	
Bone	
Brain	
Breast	
Cervical	
Colon	
Head & Neck	
Hodgkin's Disease	
Kidney	
Leukemia	
Liver	
Lung	
Melanoma	
Non-Hodgkin's Lymphoma	
Ovarian	
Pancreas	
Prostate	
Sarcome	
Skin	
Stomach	
Testicular	
Thyroid	
Uterine	
Other	

If other, specify:

_____

50. General History: Please list your family members, their age and health status:

Relation	Age	State of Health	If Deceased, cause of death	Age of Death
Father				
Mother				
Sibling				
Sibling				
Sibling				
Child				
Child				
Child				
Child				

The above information is accurate to the best of my knowledge.

_____ _____

Signature Date

Physician Signature

_____ _____

Signature Date

RN Signature

_____ _____

Signature Date

PSA/Testosterone Log

Being with the oldest date and work forward. Include ALL PSA and T results, especially those prior to your Prostate Cancer Diagnosis.

51. Start with with first time PSA measured. Click "Add More Rows" to insert additional dates/PSA.

	Date	PSA
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

52. Start with with first time T measured. Click "Add More Rows" to insert additional dates/Testosterone.

	Date	Testosterone
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

53. Office Use Only

Office Visit Date: _____

Reason for Office Visit:
☐ Primary diagnosis ☐ Second opinion ☐ Change in care

Current Disease State:

☐ Localized ☐ Rising PSA - Non-casirate ☐ Rising PSA - casirate ☐ Clinical metastatic - Non-casirate ☐ Clinical metastatic - casirate

Height:	Weight:	BSA:

54.