CHILDHOOD CANCER SURVIVORS MEDICAL HISTORY QUESTIONNAIRE

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Person completing this form: ❑ Patient ❑ Parent ❑ Other (specify: _____)

Name of Patient: _____ Date of Birth: _____/_____/_____

Cancer diagnosis: _____ Age when diagnosed: _____

What is your primary language at home? _____

Do you need an interpreter for your visit? ❑ Yes ❑ No

Do you have any current health concerns? ❑ Yes ❑ No ; If Yes describe: _____

Have your grandparents, parents or siblings had any of the following conditions?:

❑ Cancer ❑ Diabetes ❑ High Cholesterol ❑ Heart Problems ❑ Hypertension ❑Other _____

Who lives with you at home? _____

_____

What cancer treatment exposures do you remember?

❑ Chemotherapy ❑ Radiation ❑ Bone Marrow Transplant ❑ Blood Transfusion ❑ Surgery(s)

Illnesses or Surgeries NOT related to cancer

_____ Year: _____ _____ Year: _____

_____ Year: _____ _____ Year: _____

_____ Year: _____ _____ Year: _____

Do you take any medications (at least once per week) including herbal supplements?

Medication/supplement	Dose/Timing	Purpose

Do you have any allergies to medications, food, or other substances?: ❑ Yes ❑ No ❑ Don't Know

If yes describe: _____

Immunizations:

Usual childhood vaccines up to date	❑ Yes	❑ No	❑ Don't Know
Has had chicken pox disease or vaccine	❑ Yes	❑ No	❑ Don't Know
Teen/young adult vaccines:			
Diphtheria/tetanus booster (11-13 years old)	❑ Yes	❑ No	❑ Don't Know
HPV Cervical cancer vaccine	❑ Yes	❑ No	❑ Don't Know
(Recommended girls 11-26 years old)			
Boys and young men may choose to get this vaccine to prevent genital warts			
Meningococcal meningitis vaccine (11-18 years old)	❑ Yes	❑ No	❑ Don't Know

Does the *patient* have any *frequent* problems with any of the following health concerns?

General Health – **frequent problems with:**

❑ Fever ❑ Night sweats ❑ Weight loss ❑ Weight gain ❑ Fatigue
❑ Bruising ❑ New skin lesions? ❑ Changing moles?
❑ Pain/Location of Pain?:_____

Heart and Lung – **frequent problems with:**

❑ Trouble breathing ❑ Chronic cough ❑ Chest pain ❑ Irregular heartbeat or palpitations

Eyes, Ears, Nose, Mouth, & Throat - **frequent problems with:**

❑ Eye pain ❑ Excessive eye tearing ❑ Hearing problems ❑ Vision problems (Last vision test: Year _____)
❑ Eye dryness ❑ Chronic nasal congestion ❑ Neck swelling ❑ Dental problems (Last dental visit: Year _____)
❑ Neck stiffness ❑ Swallowing ❑ Other concerns (If yes, describe) _____

Stomach and Bladder - **frequent problems with:**

❑ Heartburn or regurgitation ❑ Abdominal pain ❑ Change in appetite ❑ Vomiting
❑ Constipation ❑ Diarrhea ❑ Difficulty with urination

Muscle and Bone - **frequent problems with:**

❑ Joint stiffness ❑ Other problems with joints or muscles

Nervous System - **frequent problems with:**

❑ Headaches ❑ Sleep difficulties ❑ Weakness ❑ Coordination problems ❑ Speech problems
❑ Numbness ❑ Tingling

Gynecology: for girls/women only

Have you started your period?	❑ Yes	❑ No	If yes, at what age? _____
Are periods regular?	❑ Yes	❑ No	
Do you have excessive problems with your periods?	❑ Yes	❑ No	If yes, describe: _____

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Health Behaviors – *How often does the patient:*

	Never	Sometimes	Often
Wear a helmet?	❑	❑	❑
Use sunscreen when in the sun?	❑	❑	❑
Wear a seat belt?	❑	❑	❑
Exercise?	❑	❑	❑

Teens and Young Adults Only

			Never	Sometimes	Often
❑ Married	❑ Have driver's license	Smokes cigarettes	❑	❑	❑
❑ Divorced	❑ Employed:	Drinks alcohol	❑	❑	❑
❑ Committed relationship	Job:_____	Uses drugs	❑	❑	❑

Nutrition

A healthy diet includes eating 3-5 servings of fruits and vegetables per day, eating foods that are rich in calcium (like yogurt, cheese, milk) drinking a soda only occasionally and eating fast food only in moderation. Considering this statement how would you rate your current nutrition?

❑ Great ❑ Average ❑ I could do better

Life Events – *Has patient or family experienced any of the following in the past year?*

❑ Move	❑ Death	❑ Financial problems	❑ Divorce
❑ School changes	❑ Loss of job	❑ Family member with health problem	❑ Change in child custody
❑ Birth/Adoption	❑ Legal issues	❑ Family member with mental health problems	

❑ Other: _____

How often does the patient experience the following emotions?

	Never	Sometimes	Often		Never	Sometimes	Often
Sad or down	❑	❑	❑	Angry/irritable	❑	❑	❑
Hopeless	❑	❑	❑	Nothing is fun	❑	❑	❑
Withdrawn	❑	❑	❑	Low energy	❑	❑	❑
Can't concentrate	❑	❑	❑	Tired/fatigued	❑	❑	❑
Worried/anxious	❑	❑	❑	Stressed out	❑	❑	❑

Has the patient had any previous or current counseling/mental health services? Yes ❑ No ❑

If yes, how many sessions:_____ Why did you go? _____

Activities and Interests

What do like to do in your free time (e.g., clubs, sports, hobbies, video games, etc.)?

_____

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Education/ School History

Current school (if any):_____

Current grade or grade level completed:_____ School District: _____

Is the patient having difficulty in school? ❑ Yes ❑ No

Does the patient receive special education services? ❑ Yes ❑ No ❑ Don't Know

Is the patient on a 504 Plan? ❑ Yes ❑ No ❑ Don't Know

Please describe what accommodations or help are provided at the school: _____

_____

_____

Has the patient had formal cognitive testing either at school or outside the school system? (Cognitive testing may include tests of short-term memory, attention, concentration and the ability to process information): ❑ Yes ❑ No ❑ Don't Know

If yes, when? _____ year? If through the school please bring a copy of the results with you to your appointment.

What is your estimate of the patient's performance in the following areas? (Please check the applicable column):

Skill	Below Average	Average	Above Average		Skill	Below Average	Average	Above Average
Reading					Memory			
Math					Attention/Concentration			
Study Skills					Planning			
Handwriting					Organization			
Following Directions					Total time to complete homework			

In this upcoming appointment I would like information and/or strategies in the following areas (please check all that apply):

❑ Memory, attention, concentration
❑ Post-graduate/college and career planning
❑ College or vocational scholarships for childhood cancer survivors
❑ Other _____
❑ Reading
❑ Special Education Information
❑ 504 Plan Information
❑ Study skills
❑ Math

Additional Information

In coming to this appointment, I would like to find out more about:

❑ I want an evaluation about a specific physical concern
❑ Information about effects of cancer on my body
❑ Information about cancer effects on my school work/job
❑ Medical insurance information
❑ Information about cancer effects on my thinking/emotions
❑ Other: _____