HARRINGTON
Cancer Center
A Department of BSA

Dear Patient:

Enclosed is a nursing assessment form which is a review of your past medical history and your current state of health. **Please take the time to fill it out and bring it with you to your first appointment.** The physician and/or a nurse who works with your physician will review the assessment with you during your first visit. Completing this form at home will save you time during your first visit; however, if you have difficulty completing it, a nurse will assist you after you arrive in the clinic.

In addition to your completed nursing assessment form, please bring with you **all of the medications you are currently taking.** You will also need to bring your insurance card(s), social security card and referral, if you insurance requires one.

When you arrive at the Center, you may park in the parking garage located under the south end of the building or in the parking lot in front of the building. If you park in the parking lot, the parking spaces closest to the building are reserved for patients, but you may park anywhere in the lot if the reserved spaces are already taken. From the parking lot, please enter the building from either of the ground level doors located on the right or left side of the building. Once you are inside the building, proceed to the central reception desk where a receptionist will direct you to the appropriate location for your doctor visit and completion of the registration process. If you park in the garage take the elevator to the first floor and proceed to the central reception desk on the left where you will be directed to the appropriate location.

Please feel free to call the **New Patient Inatke Desk** at (806) 212-0425 or (800) 274-4673 if you have any questions or need additional information prior to your appointment.

Sincerely,
The New Patient Intake Staff

Doctor visit with: _____

Date: _____

Registration Time: _____

Appointment Time: _____

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Nursing Assessment Form **Today's Date _____**

Please complete this form so we can identify areas in which to assist you.

1. Name _____ Date of Birth_____ Place of Birth_____
2. Married _____ Widowed _____ Divorced _____ Never Married _____
3. Occupation (if retired, previous occupation) _____
4. List all of your doctors_____ _____
5. Reason for today's appointment_____
6. Education (Circle last completed): 5 6 7 8 9 10 11 12 some college college degree post graduate
   Name of last school attended: _____
7. Drug Allergies Yes □ No □
   If yes, please list drug and reaction (hives, rash, etc.) _____
   _____
8. What pharmacy do you use? _____Location_____ Phone number _____
9. Do you have an Advanced Directive (legal documents that allow you to convey your decisions about end-Of-life care ahead of time)? Yes□ No□ If no, would you like information on this topic? Yes□ No□
10. SPECIAL NEEDS

    Do you speak English? Yes □ No □ Language spoken_____
    Can you read English? Yes □ No □
    Do you have religious beliefs that would affect your medical care? Yes □ No □
11. Do you or have you in the past used the following substance?

    Tobacco Yes □ No □ Packs/day _____ How many years _____ Date quit _____
    Alcohol Yes □ No □ Drinks/day _____ How many years _____ Date quit _____
12. Fall Assessment:
    Have you fallen in the last 6 months? _____
    Do you require the use of a walking aid (cane, walker, chair)? _____
    Do you have symptoms of dizziness, confusion or restlessness? _____
    Do you have any lack of muscle control or weakness? _____
    Are you having any problems with your vision? _____
    Do you have any problems with balance when sitting or standing? _____
    Does your home have stairs or steps? _____

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13. Current Medications: (Include over the counter preparations, hormones, birth control pills, sleeping pills, nausea, anti-depressant, pain, supplements, unconventional medications, etc.)

Drug Name	Dose	Frequency	Reason	Prescribing Physician
Chemo- yes or no				

14. Hospitalizations, surgeries, and/or cancer treatments

Date	Hospital & Location	Type of Illness, Surgery, or Cancer Treatment	If Cancer Treatment, please list type

15. Family Health

Parents	Current Health	Age and cause of death(if applic)	Comments
Siblings			

15. Self and Family History of Cancer

Relationship	Site of cancer	Living Yes / No	Age at time of diagnosis	Cause of death

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Review of Systems

Please check any of the following symptoms that you have now or have had within the *past month*.
Check 'No Problems' in each section if you have none.

System	Date	Clinic Use
CONSTITUTIONAL		
☐ No Problems		
☐ change in sleep habits		
☐ fatigue		
☐ fever-chills		
☐ pain-location _____		
☐ special diet		
☐ sweats		
☐ weight gain		
☐ weight loss		
☐ other		
NEUROLOGICAL		
☐ No Problems		
☐ blurred vision		
☐ dizziness/fainting		
☐ headache		
☐ hearing difficulty		
☐ memory changes		
☐ numbness/tingling		
☐ ringing in ears		
☐ seizures		
☐ speech changes		
☐ unbalanced walking		
☐ weakness		
☐ other		
HEAD & NECK		
☐ No Problems		
☐ difficulty swallowing		
☐ hoarseness		
☐ nose bleeds		
☐ sores in mouth or throat		
☐ sore throat		
☐ nodule/mass		
BREAST		
☐ No Problems		
☐ changes		
☐ lumps		
☐ nipple discharge		
☐ other		
Date of last mammogram:		
Do you perform monthly self breast exam? Yes ☐ No ☐		
CARDIOVASCULAR		
☐ No Problems		
☐ catheter in a vein? Y / N location:_____		
☐ chest pain		
☐ fast/irregular heartbeat		
☐ high blood pressure		
☐ leg pain/swelling		

System	Date	Clinic Use
GENITOURINARY		
☐ No Problems		
☐ dribbling /incontinent		
☐ burning		
☐ blood in urine		
☐ frequency- day or night		
☐ unable to control bladder		
☐ other		
MUSCULOSKELETAL		
☐ No Problems		
☐ bone density/scan		
☐ falls		
☐ joint/back pain/swelling		
☐ stiffness		
☐ trauma/broken bones		
☐ other		
INTEGUMENTARY		
☐ No Problems		
☐ abnormal color		
☐ change in moles		
☐ open sore		
☐ rashes		
☐ other		
ENDOCRINE		
☐ No Problems		
☐ cold intolerance		
☐ diabetes		
☐ hot flashes/night sweats		
☐ other		
HEMATOLOGIC/LYMPHATIC		
☐ No Problems		
☐ abnormal bleeding/labs		
☐ easy bruising		
☐ prior transfusion		
☐ swelling -groin/ under arm/neck		
☐ other		
PSYCHIATRIC		
☐ No Problems		
☐ Anxious/ worried		
☐ sad/depressed		
☐ other		
IMMUNOLOGIC		
☐ No Problems		
☐ flu vaccine		
☐ pneumonia vaccine		
☐ other		
☐ Genetic Testing		

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Review of Systems (continued)

System	Clinic Use	System	Clinic Use
RESPIRATORY		MALE ONLY	
☐ No Problems Date		☐ No Problems Date	
☐ bloody phlegm/sputum _____		☐ enlarged prostate _____	
☐ cough _____		☐ hormone replacement/impotence _____	
☐ shortness of breath _____		☐ problems passing urine _____	
☐ wheezing _____		Date of last prostate exam: _____	
☐ other _____		PSA: _____	
Do you use oxygen? Yes No Amount:_____		Do you perform a monthly testicle exam? _____	
GASTROINTESTINAL		Yes ☐ No ☐	
☐ No Problems Date		FEMALE ONLY	
☐ black stools/blood _____		☐ No Problems Date	
☐ change in appetite/diet _____		☐ Unusual bleeding/discharge	
☐ cramping/stomach pain _____		Age at first birth: _____	
☐ constipation _____		Do you use birth control? Yes No	
☐ drain, tube, catheter, or ostomy? Y or N Location:_____ _____		Are you pregnant? Yes No	
☐ diarrhea _____		Did you breastfeed? Yes No	
☐ indigestion/ reflux _____		Breastfeeding a baby now? Yes No	
☐ hemorrhoids _____		Age menstrual cycle began: _____	
☐ last colonoscopy_____ _____		Last menstrual period _____	
☐ nausea/vomiting _____		Were cycles regular? Yes No	
☐ problems swallowing _____		# days of period _____	
☐ sore mouth _____		Age at menopause:_____	
☐ yellow skin or eyes _____		Last Pap smear _____ _____	
		# of pregnancies _____	
		# deliveries- vaginal____ C/S_____	
		Hormone replacement Yes No	
		Date you stopped hormones:_____	
		Hysterectomy Yes No Date_____	

Please check all of the following items which are a concern or problem for you:

- ☐ Work/school
- ☐ Finances
- ☐ Transportation
- ☐ lodging
- ☐ Medical expenses
- ☐ Assistance at home
- ☐ Feeling a burden to others
- ☐ Worry about friends/family
- ☐ Feeling alone/isolated
- ☐ Relationship difficulties
- ☐ Social Activities participation
- ☐ Changes in appearance
- ☐ Frustration/anger
- ☐ Intimacy/sexuality
- ☐ Weight gain/loss
- ☐ Wellness concerns
- ☐ Spiritual-purpose, faith
- ☐ Grief/Loss
- ☐ Quit Tobacco/Staying quit
- ☐ Understanding diagnosis/treatment
- ☐ making treatment decisions
- ☐ Fear of recurrence
- ☐ Concentration/memory
- ☐ Sleep
- ☐ Exercise
- ☐ Body image

Please circle the number that best describes how distressed you are today and in the past week:

Extreme 10	9	8	7	6	5

Who completed this form? Patient ☐ Relative ☐ Friend ☐ Other ☐

Patient sticker

Staff Use Only:

Reviewed by: _____ Date: _____

Who, if any, is with the patient today? _____

Interventions: _____

_____

In-House MD Referral-

Reviewed by: _____ Date: _____

Who, if any, accompanied the patient today? _____

Prior to referral: (for this diagnosis)

- Chemo - Dates_____ Meds_____ None___
- Radiation therapy – Yes/Dates_____Site_____, None___

Concurrent radiation and chemo for this diagnosis? Yes/Dr's Name_____No____

Interventions: _____

_____

Referrals made: **(examples)**

	Date/Initial	Date/Initial	
Physical: _____ (equipment, lymph edema, wig, help at home)			
Emotional: _____ (depression/anxiety, counseling, support groups)			
Financial :_____(work/school, disability, assistance, med expense)			
Tobacco Cessation :_____(smoking, oral or both)			
Pain Management :_____(location)			
Nutrition :_____(wt loss/gain, healthy info, loss of appetite, concerns)			
Resources :_____(lodging, transportation, disabled parking permit, drug assistance)			
Spiritual :_____(meaning/purpose, faith, grief/loss)			
Caregiver info: _____			
Educational :_____(Chemo/RT class, disease, intimacy, sexuality, self care,			Port)
Genetic Testing: _____			

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