Cancer Rehabilitation Program New Patient Questionnaire
A Collaboration of Courage Kenny Rehabilitation Institute,
Virginia Piper Cancer Institute and Allina Health

Please bring completed form to your appointment or fax prior to your appointment to 612-863-8942.

Section One: Background Information

Name: _____

Date of Birth: _____

Reason for appointment: _____

Referred by: _____

Primary Care Provider: Name, Address, & Fax: _____

_____

Specialty Care Providers: Names, Full Addresses, & Faxes (Please attach separate sheet if needed):

_____

_____

_____

_____

Section Two: Cancer

Please list all types/locations of cancer: _____

_____

_____

_____

Cancer Treatment: Please describe your cancer treatment, list types of treatment (including surgery, chemotherapy, radiation therapy or other cancer treatments).

_____

_____

_____

_____

_____

Did you experience any major complications from your cancer treatment? Please describe:

_____

_____

PATIENT LABEL

Section Three: PsychoSocial History

Family History: Please list all family members with a history of cancer and/or swelling, what problem they each had, along with their relationship to you:

_____

_____

_____

Social History:

Marital Status: ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Life Partner**

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired

What is/was your occupation? _____

_____

Daily Activities: Please list any activities that are performed on a daily basis (i.e. type of work, hobby, home chores, home making, etc.):

_____

_____

Physical Activity History: Do you or have you ever exercised regularly? Describe.
What would you like to be able to do for exercise? _____

_____

_____

What is the one activity you cannot do now that you most wish you could do?

_____

_____

_____

Section Four: Medical History Have you ever had any of the following? If yes, please describe. Use additional sheet or add an attachment if necessary:

I. Fevers, Fatigue, Weakness: _____

II. Infections or immune system problems: _____

_____

III. Ear, Eyes, nose, throat, sinus problems: _____

_____

_____

IV. Cardiovascular (heart disease, hypertension, heart surgery, vein or artery disorder or surgery, coagulation disorder or therapy):

_____

V. Lung (asthma, emphysema, cancer, lung surgery, etc.):

_____

VI. Gastrointestinal including stomach, intestinal, bowel: _____

VII. Kidney, Bladder, Urinary: _____

VIII. Endocrine including diabetes, thyroid: _____

IX. Skin diseases or skin conditions of any type, history of poisonous bite, rash:

_____

X. Muscular or joint problem, trauma, injury or surgery: _____

XI. Pain or limited range of motion: _____

XII. Neurologic problem: neuropathy, stroke, migraines, brain tumor:

_____

XIII. Difficulty walking or balancing: _____

XIV. Difficulty with hands or dexterity: _____

XV. Difficulty with speech or swallowing: _____

XVI. Mental Health (depression, anxiety, chemical abuse, memory problems, hospitalizations for mental health-please include all dates): _____

_____

_____

Section Five: Swelling & Edema

(Fill out if you have **Swelling** or **Edema**. If no swelling, skip to **Section Six**)

Swelling history: _____

_____

_____

_____

_____

Please list locations of swelling: _____

Please list approximate date of onset: _____

Has the swelling gotten better, worse, or stayed the same? What makes it get better or worse?

Please list all treatments that have been tried including medications, bandages, garments, lymphedema therapy by a PT or OT lymphedema therapist.

Have you ever had wounds? Please provide dates. Please provide treatment that was administered:

Have you ever had cellulitis or infection related to edema? Please list approximate dates. Please include treatment including hospitalizations, antibiotics, topical preparations, creams and lotions.

Have you ever had surgery or procedures performed for edema, veins, weight loss, or plastic surgical procedures? Please provide the date and result of each procedure.

Have you ever had a blood clot in your arm or leg? Please list all occurrences and treatments.

PATIENT LABEL

Section Six: Meds/Allergies

Medications: List all medications you take regularly or irregularly. Include over the counter medications, vitamins, supplements. Please include generic name and dosages. Attach a separate sheet if necessary. _____

_____

_____

_____

_____

Allergies: Please list all allergies to medications and your reactions to them.

_____

_____

_____

_____

How do you learn best?

☐ Discussion ☐ Reading ☐ Demonstration ☐ Visual ☐ Classroom

☐ Individual Instruction ☐ Other _____

Signature (of Patient or person filling out the form)

_____ Date: _____ Time: _____

Name of person filling out this form if not the patient _____

Relationship to patient _____