Virginia Piper Cancer Institute
Palliative Medicine Clinic
310 N Smith Avenue Suite 300
St. Paul MN 55102
651-241-5111

Attach Patient Label Here

Initial Patient History

Please complete to the best of your ability prior to your appointment.

Name: _____ **Date:** _____

Primary Doctor: _____

Doctor who referred you to this appointment: _____

Reason for your visit: _____

What would you like addressed at this visit? _____

As you live with illness and its effect on your life…

What other healing therapies are you finding helpful? _____

What helps you relax? _____

What spiritual beliefs or practices, if any, do you find helpful? _____

What gives your life meaning? _____

What stresses or worries are adding to the challenges you face at this time? _____
_____

What person/persons is/are the greatest support to you? _____
_____

What are the hopes/needs/concerns of your loved ones in terms of your illness? _____
_____

Advanced Care Planning:

Have you completed a health care directive ("living will")? _____

Who would you want to make medical decisions on your behalf if you were unable to speak for yourself? _____

Medical History: please list your medical problems (past or current illnesses, chronic conditions, hospitalizations, surgeries)

_____
_____
_____
_____
_____

Family history: Has anyone in your family had an illness similar to yours? (For example, if you have cancer, has anyone in your family had any kind of cancer?)

_____
_____
_____

Lifestyle:

Work:	
Exercise:	What kind? How often?
Hobbies:	
Smoking:	Packs per day? If you quit, when?
Alcohol:	Drinks per day or per week?

Please circle any symptoms you have had in the past 6 months.

General	Weight gain Weight loss Loss of appetite Fatigue Fevers
Vision	Change in vision Red or painful eyes
Hearing	Hearing loss Ringing in your ears
ENT	Nose bleeds Dental problems Mouth sores Swallowing problems
Lungs	Shortness of breath Cough Wheezing/asthma
Heart	Chest pain Rapid heartbeat or palpitations Passing out Swelling
Digestive	Nausea Vomiting Heartburn Ulcers Constipation Diarrhea Blood in stool
Urinary	Painful urination Blood in urine Kidney stones
Musculoskeletal	Joint pain Muscle pain Joint swelling Tendonitis Bursitis
Skin	Rashes Growths or spots
Nerve	Numbness Seizures Headaches Balance problems Tremors/shakes
Endocrine	Excessive thirst or hunger Problems with sexual function
Lymph	Enlarged lymph nodes Lymphedema
Mental Health	Depression Anxiety Problems with drugs/alcohol Memory problems
Allergy	Any new allergies??