Children's Cancer and Blood Disorders Program Randall Children's Hospital Legacy Emanuel
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Name of Patient: _____ Date of Birth: _____/_____/_____
Cancer diagnosis: _____ Age at diagnosis: _____
At which hospital did you receive your cancer treatment?_____
Current Primary Provider:_____

Teens and Young Adults Only:
Are you: □ Married □ Divorced □ In a committed relationship
□ Employed (what is your job?_____)

Family History:
In my family there is a history of:
□ Diabetes □ High blood pressure □ Cancer □ High cholesterol
□ Other:_____

Immunizations:
Immunizations are up to date? □ Yes □ No □ Don't know
Please bring a copy of your immunizations records if available.

What cancer treatment exposures do you remember?
□ Chemotherapy □ Radiation □ Bone Marrow Transplant □ Blood Transfusion □ Surgery(s)

Illnesses or Surgeries NOT related to cancer
1. _____ Year:_____
2. _____ Year:_____
3. _____ Year:_____
4. _____ Year:_____
5. _____ Year:_____

Please list any medications, supplements, or herbal supplements you are taking
1. _____
2. _____
3. _____
4. _____
5. _____

Do you have any allergies to medications, food, or other substances? □ Yes □ No □ Don't know
If yes, please describe:_____

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

General Health:

□ Fever □ Night sweats □ Weight loss □ Weight gain □ Fatigue
□ Bruising □ Skin changes □ Changing moles □ Pain (pain location:_____)

Heart and Lung:

□ Trouble breathing □ Cough □ Chest pain □ Irregular heartbeat or palpitations
□ Shortness of breath on exertion or with exercise

Eyes, Ears, Nose, Mouth, and Throat:

□ Eye pain □ Excessive eye tearing □ Eye dryness □ Vision problems (Last vision test: _____)
□ Swallowing □ Hearing problems □ Neck swelling □ Dental problems (Last dental visit: _____)
□ Chronic nasal congestion □ Other concerns (please describe:_____)

Stomach and Bladder

□ Heartburn or regurgitation □ Abdominal pain □ Change in appetite □ Vomiting
□ Constipation □ Diarrhea □ Difficulty with urination
□ Blood in urine

Muscle and Bone:

□ Joint stiffness □ Other problems with joints/muscles (please describe: _____)

Nervous System:

□ Headaches □ Sleep difficulties □ Weakness □ Coordination problems
□ Speech problems □ Numbness □ Tingling □ Blurry vision
□ Vision changes

Gynecology: for females only

Have you started your period? □ No □ Yes (age that periods started: _____)
Are your periods regular? □ No □ Yes
Do you have any problems with your periods? □ No □ Yes (please describe: _____)

Dental:

Do you see a dentist for routine cleanings? □ Yes (last visit?_____) □ No
Do you have or have you had cavities? □ Yes □ No
Have you ever had dental surgery? □ Yes □ No
Do you have any current dental pain? □ Yes (how long?_____) □ No

Health Behaviors: Do you/the patient:

Wear a helmet	□ Never	□ Sometimes	□ Often
Use sunscreen	□ Never	□ Sometimes	□ Often
Wear a seat belt	□ Never	□ Sometimes	□ Often
Exercise	□ Never	□ Sometimes	□ Often
Smoke cigarettes	□ Never	□ Sometimes	□ Often
Drink alcohol	□ Never	□ Sometimes	□ Often
Use drugs	□ Never	□ Sometimes	□ Often

Nutrition:
Good nutrition includes a diet of whole grains, a variety of fruits and vegetables, lean meats, and calcium-rich foods (cheese, yogurt, milk) eaten in the appropriate amounts. Considering these statements, how would you rate your current nutrition?
□ Great □ Average □ I could do better

A nutritionist can work with you and your family to help develop and encourage healthy eating habits.
Do you have any interest in meeting with a nutritionist? □ Yes □ No

Have you thought about making changes to you diet to improve your nutrition? □ Yes □ No
If yes, please explain: _____

Life Events:
Who lives with you at home?_____
Have you/the patient or family experienced any of the following?
□ Move □ Death □ Financial problems □ Divorce
□ School changes □ Legal issues □ Family member with health problems □ Loss of job
□ Birth/Adoption □ Change in child custody
□ Other: _____

How often do you/the patient experience the following emotions?

Sad or down	□ Never	□ Sometimes	□ Often
Hopeless	□ Never	□ Sometimes	□ Often
Withdrawn	□ Never	□ Sometimes	□ Often
Poor concentration	□ Never	□ Sometimes	□ Often
Worried/anxious	□ Never	□ Sometimes	□ Often
Angry/irritable	□ Never	□ Sometimes	□ Often
Tired/fatigued	□ Never	□ Sometimes	□ Often
Stressed	□ Never	□ Sometimes	□ Often

Has the patient had any previous counseling/mental health services? □ Yes □ No
Is yes, who did you see? _____ When?_____
Why did you go? _____

Activities and Interests
How are your relationships with friends/peers? _____
What do you like to do in your free time (sports, clubs, hobbies, video games, etc.)?
_____

Education/School History:
Current School (if any): _____
Current grade/grade level completed: _____ School District: _____
Please bring a current transcript if available.

Is the patient having difficulty in school? □ Yes □ No
Does the patient receive special education services? □ Yes □ No □ Don't know
If yes, do you feel that this has been helpful? □ Yes □ No □ Don't know
If the child has an IEP in place, please bring a copy with you to your appointment.

Is the patient on a 504 Plan? □ Yes □ No □ Don't know

If yes, what accommodations is the child receiving: _____

_____

Do you feel that this has been helpful? □ Yes □ No □ Don't know

If the child has a current 504 plan, please bring a copy with you to your appointment.

Has the child even been evaluated or tested by a school psychologist or neuropsychologist?:

□ Yes (if yes, when? _____) □ No □ Don't know

If the child has completed this testing, please bring a copy of results to your appointment.

Have you noticed any changes if your child's attitude towards school? □ Yes □ No

If yes, please describe:_____

Have you noticed any specific changes in the way your child is learning new material? □ Yes □ No

If yes, please describe:_____

Is your child able to retain recently learned material for assignments? □ Yes □ No

Are there any specific subjects that are causing challenges for the child? □ Yes □ No

If yes, please list subjects:_____

What is your estimate of the child's performance in the following areas?

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

In this upcoming appointment I would like information and/or strategies in the following areas:

□ Memory, attention, concentration □ Reading □ Math

□ Post-graduate/college career planning □ Special Education Information

□ College or vocational scholarships for childhood cancer survivors □ 504 Plan Information

□ Study Skills □ Other _____

Additional Information

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

□ Effects cancer and cancer treatment on my body

□ Effects of cancer and cancer treatment on my school, work, or job

□ Effects of cancer and cancer treatment on my thinking/emotions

□ Available programs for childhood cancer survivors (adventure retreat programs, organizations to connect with other survivors, etc.)

□ I have a specific concern I would like to discuss at my next visit:_____

□ Other:_____

_____