Main Line Health
Cancer Center
Paoli Hospital
Fox Chase Cancer Center Partner

Patient ID

Universal Health Assessment

In order to understand your general health, we would ask you to take a few minutes and complete the following questions before you see your doctor. Thank you for your assistance.

Patient Name_____ Date of Birth_____

Medical History

Do you have or have you had?

	YES	NO		YES	NO		YES	NO
Stroke or TIA	_____	_____	Asthma	_____	_____	Kidney Failure/Dialysis	_____	_____
Seizures	_____	_____	Tuberculosis	_____	_____	Shingles	_____	_____
Headaches/Migraine	_____	_____	COPD	_____	_____	DVT or PE	_____	_____
Cataracts	_____	_____	Bronchitis / Pneumonia	_____	_____	Bleeding Problems	_____	_____
Glaucoma	_____	_____	Sleep Apnea	_____	_____	Anemia	_____	_____
Hearing Deficit	_____	_____	Acid Reflux/Ulcers	_____	_____	Lupus	_____	_____
Diabetes	_____	_____	Gallbladder Problems	_____	_____	Osteoporosis	_____	_____
Hyper/Hypothyroidism	_____	_____	Colitis or diverticulitis	_____	_____	Arthritis	_____	_____
High Blood Pressure	_____	_____	Crohn's Disease	_____	_____	Depression	_____	_____
Heart Failure/Attack	_____	_____	Regional Enteritis	_____	_____	Anxiety	_____	_____
High cholesterol	_____	_____	Hepatitis	_____	_____	Cancer	_____	_____
Atrial Fibrillation	_____	_____	Prostate Difficulties	_____	_____	Hormone Therapy	_____	_____
Pacemaker/Defib.	_____	_____	Kidney Stones	_____	_____	Chemotherapy	_____	_____
						Previous Radiation	_____	_____

Surgeries & Hospitalizations:

Date	Reason	Location

Cancer or Hematology -Family History:

Family Member	Age	Alive?	Cancer Diagnosis/Hematological Disorders
Father		Yes____ No____	
Mother		Yes____ No____	
Siblings		Yes____ No____	
Grandparents		Yes____ No____	
Other		Yes____ No____	

Have you or anyone else in your family had?

Cancer before age 50? Type_____ Who_____
Ovarian cancer at any age? Yes_____ No_____ Who_____
Male breast cancer? Yes_____ No_____ Who_____
10 or more colon polyps? Yes_____ No_____ Who_____

Social History:

Do you drink alcohol or have a history of drinking? Yes_____ No_____ Type_____ # per week_____

Do you smoke or have a history of smoking? Yes_____ No_____ Packs per day_____ x _____years, Quit_____

Are you working? Yes_____ No_____ Occupation/Previous Employment_____

Who lives at home with you? (Please circle) I live Alone Spouse Children Parents Other_____

Do you ….	Have concerns about health insurance or prescriptions?	Yes_____	No_____
	Need help caring for your children? Or parents?	Yes_____	No_____
	Need help with rides getting to and from your appointments?	Yes_____	No_____
	Have trouble getting meals?	Yes_____	No_____
	Have trouble washing or getting dressed?	Yes_____	No_____
	Trouble with housekeeping?	Yes_____	No_____

Do you have an Advance Directive or Living Will? ☐ Copy Provided Yes_____ No_____

If **No**, would you be interested in information regarding Advanced Directives or in speaking with our Social Worker? Yes_____ No_____

Have you been experiencing any threats, mental abuse, neglect, or domestic violence? Yes_____ No_____

Any Spiritual or Cultural practices? _____

Review of Systems:

Are you experiencing any Pain? Yes_____ No_____ Intensity (0-10) _____

Location(s): _____

Describe your pain (circle all that apply) Sharp Stabbing Burning Aching Constant Intermittent

What makes the pain worse? _____

What makes the pain better? _____

Have you noted any recent changes with: (Constitutional)	Weight gain or loss in last 6 months	Yes_____	No_____
	Loss of appetite	Yes_____	No_____
	Always feeling hungry or thirsty	Yes_____	No_____
	Fevers/Chills	Yes_____	No_____
	Night sweats	Yes_____	No_____
	Problems with sleeping	Yes_____	No_____
Do you have any problems with: (Head and Neck)	Headaches	Yes_____	No_____
	Dizziness or lightheadedness	Yes_____	No_____
	Lumps or swelling in the neck	Yes_____	No_____
	Sore throat	Yes_____	No_____
	Swallowing	Yes_____	No_____
	Soreness in the neck or shoulder	Yes_____	No_____
Do you have any problems with: (Eyes, Ears, Nose, Throat)	Recent change in vision	Yes_____	No_____
	Blurred or double vision	Yes_____	No_____
	Eye Infections	Yes_____	No_____
	Do you wear glasses or contacts	Yes_____	No_____
Do you have hearing aids? Yes_____ No_____	Changes in hearing	Yes_____	No_____
	Buzzing or ringing in the ears	Yes_____	No_____
	Frequent earaches or ear infections	Yes_____	No_____
	Motion sickness	Yes_____	No_____
	Frequent sinus problems or colds	Yes_____	No_____
	Recurrent nose bleeds	Yes_____	No_____
Do you wear dentures? Yes_____ No_____	Mouth Pain or difficult chewing	Yes_____	No_____
	Bleeding gums or mouth sores	Yes_____	No_____
	Taste changes	Yes_____	No_____
	Hoarse voice or difficulty talking	Yes_____	No_____

Do you have any problems with: (Respiratory System)	Difficulty or painful breathing	Yes_____	No_____
	Shortness or breath at rest	Yes_____	No_____
	Cough	Yes_____	No_____
	How many blocks can you walk before you are out of breath?	_____	
	Has this changed recently?	Yes_____	No_____
	Can you climb a flight of steps without resting?	Yes_____	No_____
	On how many pillows do you sleep?	_____	
	Have you had a cough that has lasted for more than 2 weeks?	Yes_____	No_____
	Have you coughed up phlegm daily for more than 2 weeks?	Yes_____	No_____
	If yes, what color was the phlegm?		
Vaccinations & Resistant Infections	Have you had a flu shot?	Yes_____	No_____
	Have you had a Pneumonia shot?	Yes_____	No_____
	Any history of infections with C-Diff, MRSA, VRE?	Yes_____	No_____
Do you have problems with: (Cardiovascular System)	Chest pain	Yes_____	No_____
	Palpitations or irregular heart beat	Yes_____	No_____
	Heart Murmur	Yes_____	No_____
	Ankle swelling	Yes_____	No_____
	Poor circulation	Yes_____	No_____
	Port-A-Cath, PICC, central line		
	Type _____ Location_____	Yes_____	No_____
Do you have problems with: (Gastrointestinal System)	Nausea and vomiting	Yes_____	No_____
	Vomiting blood	Yes_____	No_____
	Constipation	Yes_____	No_____
	Black stools	Yes_____	No_____
	Jaundice	Yes_____	No_____
	Blood in the stools	Yes_____	No_____
	Diarrhea	Yes_____	No_____
	Does food ever get stuck, come back up, or make you gag?	Yes_____	No_____
	How many bowel movements do you have per day?	_____	
	Do you have a feeding tube? Or receive TPN?	Yes_____	No_____
	When was your last colonoscopy?	_____	
	Were any polyps removed?	_____	
	When is your next colonoscopy due?		
Do you have problems with: (Musculoskeletal)	Bone or joint pain	Yes_____	No_____
	Joint swelling or stiffness	Yes_____	No_____
	Muscle pain or weakness	Yes_____	No_____
	Sciatica	Yes_____	No_____
	Broken bones	Yes_____	No_____
	Falls	Yes_____	No_____
	Do you walk with a cane, walker, or crutches?	Yes_____	No_____
Do you have problems with: (Neurological System)	Weakness in the arms or legs	Yes_____	No_____
	Changes in coordination or balance	Yes_____	No_____
	Shaking or tremors	Yes_____	No_____
	Loss of consciousness or passing out	Yes_____	No_____
	Difficulty in working with numbers	Yes_____	No_____
	Difficulty thinking of words	Yes_____	No_____
	Difficulty speaking	Yes_____	No_____
	Changes in memory	Yes_____	No_____
	Changes in handwriting	Yes_____	No_____
	Difficulty holding a pen, pencil, or cup	Yes_____	No_____
	Claustrophobia	Yes_____	No_____
	Change in personality	Yes_____	No_____

Do you have problems with: (Skin)			
	Itching or burning of the skin	Yes_____	No____
	Easy bruising or bleeding of the skin	Yes_____	No_____
	Rashes	Yes_____	No_____
Do you have problems with: (Genitourinary System)			
	Painful or frequent urination	Yes_____	No_____
	Difficulty emptying your bladder	Yes_____	No_____
	Split stream or difficulty controlling urination	Yes_____	No_____
	Difficulty starting urination	Yes_____	No_____
	Urgency to urinate without warning	Yes_____	No_____
	Dribbling or loss of control of urine	Yes_____	No_____
	Blood in urine	Yes_____	No_____
	Kidney stones	Yes_____	No_____
	Sexually transmitted diseases	Yes_____	No_____
	Do you experience nighttime urination?	Yes_____	No_____
	How many times a night?	_____	

For Men:

Have you ever noticed any change in sexual function of the last 2 years? Yes_____ No_____

Date of last rectal examination _____ Date of last Physical Examination _____

For Women:

Have you ever been pregnant? Yes_____ No_____ Your age with your 1st child _____

# of Pregnancies _____ Live Births _____ Miscarriages _____ Abortions _____

Age of 1st menstrual period _____ Date of Last Menstrual Period _____

Have you gone through menopause? Yes_____ No_____ If yes, how old were you? _____

Previous Hormones or Birth Control? Yes_____ No_____ #of Years_____ Type_____

Any sexual Concerns? Yes_____ No_____ Explain:_____

Have you had any discharge or bleeding from the vagina? Yes_____ No_____

Have you ever had any operations or infections of the uterus, fallopian tubes, or ovaries? Yes_____ No_____

Do you have any lumps, swelling or tenderness of the breasts? Yes_____ No_____

Do you have any pain or bleeding during intercourse? Yes_____ No_____

Date of last pelvic exam _____ Date of last breast exam _____

Date of last PAP smear _____ Date of last mammogram _____

Date of last general physical examination _____

Reviewed By: _____ Date: _____ Time: _____

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Please complete by referencing your medications at home. This will give us thorough record of your medications and dosages. Thank you.

Allergies

Allergy (Drug, Food, Latex, Tape, Dyes)	Reaction

Medications

Drugs/Herbals/Over-the-Counter	Dose	Number of pills	Times per day	Reason for Medication

Pharmacy Name: _____ **Location:** _____ **Phone #:**_____