CONSULTATION

TO BE COMPLETED BY THE PATIENT

Karmanos CANCER INSTITUTE | McLaren FLINT
Medical Oncology Department
4100 Beecher Road, Suite B, Flint, MI 48532 • (810) 235-8568

Date: _____ Patients Name: _____

Completed by: _____ Birth Date: _____

Primary Doctor: _____ Do you currently reside in a Nursing Home? Yes ☐ No ☐

Reason you are being referred to us? _____

Please list your types of illnesses, medical & surgical experiences with dates: _____

_____

_____

_____

List ***ALL*** Medications: _____

_____

_____

Allergies: _____ Diabetic: ___ Yes ___ No

Social History (circle one): Single Married Divorced Widowed

Occupation(s) past and present: _____

Tobacco use: years ___ Amount ___ quit ___ Alcohol use: years ___ Amount ___ quit ___

FEMALES

Age at first Menses_____ Age at first pregnancy_____ Hormonal usage_____ Hysterectomy? _____

Number of pregnancies_____ Births _____ Date of last Menstrual Period: _____

Please indicate your overall current pain level based on a scale of 1 to 10 (***1 = no pain ~ 10 = Worst ever***): _____

Do you have or are you currently experiencing any of the complaints listed below? If so, please indicate with a ✓ mark.

	✓
Fatigue	
Loss of Appetite	
Weight Loss	
Drenching Night Sweats	
Fever/Chills	
Blurred/Double Vision	
Hearing Loss	
Nasal Drainage/Congestion	
Nose Bleeds	
Sore Throat	
Trouble Swallowing	
Hoarseness	
Shortness of Breath	
Productive Cough	
Non-Productive Cough	

	✓
Blood in Sputum	
Chest Pain	
Palpitations	
Swelling in Legs	
Nausea	
Vomiting	
Diarrhea	
Constipation	
Abdominal Pain	
Rectal Bleeding	
Bowel Incontinence	
Pain/Burning with Urination	
Blood in Urine	
Frequent Urination	
Urinary Incontinence	

	✓
Muscle Pain/Stiffness	
Joint Pain/Swelling	
Back Pain	
Skin Rash	
Headaches	
Dizziness	
Loss of Sensation	
Tingling	
Anxiety	
Depression	
Difficulty Sleeping	
Bruising/Bleeding	
Lumps in Neck	
Lumps in Armpit	
Lumps in Groin	

Any other complaints not listed above? _____

Do you have a pacemaker or any metal in your body? Yes ☐ No ☐ If Yes, please describe. _____

Do you have personal reasons that prohibit the use of blood or blood by-products in your treatment? Yes ☐ No ☐

Have you had a Colonoscopy? Yes ☐ No ☐ If Yes, When? _____ Where? _____

Patient Signature: _____ Date: _____

I have reviewed all of the above information in detail with this patient.

Dr. Signature: _____ Date: _____