Hartford Hospital
Rehabilitation Network

Hartford Hospital Rehabilitation Network Medical History – Oncology

Name: ____ DOB: ___________________________ AGE: __________________

Emergency Contact: ________________________ Phone: ________________ Referring Physician:______________________

Surgeon: __________________ Medical Oncologist: __________________ Plastic Surgeon: ___________________________

Radiation Oncologist: ________________________ Primary Care Physician & Phone: _________________________________

Email Address: ____

Involved Body Region/s: ☐ Right arm ☐ Left arm ☐ Right Breast/chest wall ☐ Left Breast/chest wall

☐ Right Leg ☐ Left Leg ☐ Mid Back ☐ Low Back ☐ Pelvis ☐ Head/Neck

Cancer Type: ☐ Breast ☐ Prostate ☐ Ovarian ☐ Cervical ☐ Endometrial ☐ Melanoma ☐ Lung ☐ Brain

Other: ____

Chief Complaint/Reason for referral to Physical/Occupational Therapy? ____________________________________

Surgical History: Date of Surgery: ________________________ Date of Diagnosis: _______________________________

☐ Lumpectomy ☐ Mastectomy ☐ Breast Expanders ☐ Breast Implants ☐ DIEP Flap ☐ TRAM flap

☐ LAT Flap ☐ Prostatectomy ☐ Pelvic ☐ Abdominal Other: ____

Any Lymph nodes removed? ☐ No ☐ Yes Number removed _______________________________

How many positive for cancer? ________________________ Location of lymph node removal __________________________

History of Treatment:

☐ Chemotherapy # of treatments: _________________ Date completed: ______________ Type: ______________________

☐ Radiation # of treatments: __________________ Date completed: _______________ Location: ___________________

Type: ____

☐ Hormone Therapy ☐ yes ☐ no ☐ Tamoxifen ☐ Arimidex ☐ Femora ☐ Aromasin Other: _________________________

☐ Bone Marrow Transplant ☐ Infection/Cellulitis ☐ Antibiotics: ____

☐ **Port cath** placement/location____

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MEDICAL HISTORY: (please check all that apply):

☐ Diabetes ☐ Vascular Problems ☐ High Blood Pressure ☐ History of Heart Attack ☐ Pregnant

☐ Active Cancer ☐ Broken Bones ☐ High Thyroid ☐ Latex Allergy ☐ Pacemaker

☐ Allergies ☐ Metal Implants ☐ Respiratory Problems ☐ Kidney Disease ☐ Incontinence

☐ Irregular Heart Beat ☐ Osteopenia/Osteoporosis ☐ Stroke/Paralysis ☐ Congestive Heart Failure

☐ History of Blood Clots ☐ Psychological ☐ Arthritis Other: ____________________

Other Surgeries (list dates)

Hand Dominence: Right ___ Left___

Medications:____

Diagnostic Reports for Current Cancer Diagnosis:

Recent Lab work (and results) : ☐ MRI ☐ Ultrasound (to rule out blood clots):_______________

☐ Pet Scan ☐ L-Dex ☐ MUGA Other: ____

Symptoms/Side Effects of Treatment:

SWELLING:

1. If you have lymphedema (swelling of your arm, breast, chest wall, leg , head/neck, genitals, other area) how did the lymphedema develop and when did it start?
2. Have you had previous treatment for your lymphedema? ☐ Yes ☐ No ☐ Pump ☐ Garments ☐ Compression Bandages ☐ Diuretics other: Please list details: ____
   ____
3. Do you wear a compression sleeve/garment and/or short stretch bandages at night? ☐ Yes ☐ No
4. Have you ever leaked lymph fluid or had open sores on the affected limb/area? ☐ Yes ☐ No

Chemo Induced Peripheral Neuropathies (CIPN):

1. Do you have any of the following symptoms in your feet or hands ? ☐ No ☐ Yes (If yes circle all that apply and list location):
   Numbness and tingling ___________________ Weakness _______________ Pain________________________

BALANCE:

1. Have you fallen since your diagnosis? ☐ Yes ☐ No ; If yes , how many times?
2. Have you lost your balance, but not fallen? ☐ Yes ☐ No ; if yes, how many times?
3. Do you have a fear of falling? ☐ Yes ☐ No

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FUNCTION:

Do you have difficulty moving your arms, legs or neck due to your treatment? ☐ No ☐ Yes

Do you have difficulty getting in/out of bed, chairs, or with walking? ☐ No ☐ Yes

FATIGUE:

1. Have you felt unusually tired or fatigued since your diagnosis? ☐ Yes ☐ No
2. If yes, circle the number that best describes how fatigue has interfered with your:

	Does not interfere										Completely Interferes
Usual Activity	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Work (includes both work	0	1	2	3	4	5	6	7	8	9	10
Outside the home and daily chores	0	1	2	3	4	5	6	7	8	9	10

Cognition:

1. Do you have difficulty with memory, concentrating, or multitasking since your diagnosis? ☐ Yes ☐ No

Speech/Language:

1. Do you have difficulty with chewing or swallowing? ☐ Yes ☐ No
2. Do you have difficulty speaking? ☐ Yes ☐ No
3. Do you have difficulty understanding others or others understanding you? ☐ Yes ☐ No

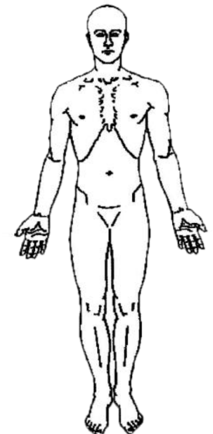
Please rate your pain right now on a scale of 0-10

0 being no pain; 10 being the worst pain imaginable:

0—1—2—3—4—5—6—7—8—9—10

What would you rate your pain at its lowest? __ /10

What would you rate your pain at its highest? __ /10



Please describe your pain (circle all that apply):

Constant intermittent sharp dull aching burning tingling stabbing throbbing shooting cramping

On the diagram mark an X for areas of pain and an O for areas of numbness/tingling.

What makes pain worse? ____________________________ What makes pain less?_____________________

Do you have a Do Not Resuscitate (DNR) Order?
☐ Yes If yes, please notify your therapist
☐ No

Patient's signature ____________________________________ **Date:** ______________________________