HPI ONCOLOGY

History of Present Illness

Why are you here today? (Select all that apply)

- ☐ a fall/decreased balance
- ☐ a surgery
- ☐ cancer treatment
- ☐ decreased endurance
- ☐ decreased mobility
- ☐ decreased range of motion
- ☐ fatigue
- ☐ neuropathy
- ☐ pain
- ☐ swelling
- ☐ weakness

Additional Comments:

On what date did this occur?

Do you have pain? Yes | No

Which side? (Select all that apply)

- ☐ left
- ☐ right

Where is this pain located? (Select all that apply)

- ☐ neck
- ☐ arm
- ☐ hand
- ☐ hip
- ☐ ankle
- ☐ upper back
- ☐ lower back
- ☐ mid back
- ☐ leg
- ☐ foot
- ☐ shoulder
- ☐ chest
- ☐ buttock
- ☐ genital/groin
- ☐ mouth
- ☐ throat

What makes this pain worse? (Select all that apply)

- ☐ twisting
- ☐ squatting
- ☐ standing
- ☐ sitting
- ☐ walking
- ☐ stair climbing
- ☐ prolonged sitting
- ☐ bending
- ☐ driving
- ☐ overhead reaching
- ☐ repetitive movement
- ☐ swallowing
- ☐ sidelying
- ☐ lying on back
- ☐ lying on stomach
- ☐ chewing
- ☐ medication

What makes this pain better? (Select all that apply)

- ☐ nothing
- ☐ rest
- ☐ ice
- ☐ heat
- ☐ immobilization
- ☐ sitting
- ☐ pain medication
- ☐ bracing
- ☐ elevation
- ☐ standing
- ☐ walking

How would you describe this pain? (Select all that apply)

- ☐ dull
- ☐ sharp
- ☐ aching
- ☐ throbbing
- ☐ shooting
- ☐ constant
- ☐ intermittent

Have you had any diagnostic tests done? Yes | No

If yes, select all that apply.

- ☐ Xray
- ☐ MRI
- ☐ CT
- ☐ PET scan
- ☐ stress test
- ☐ bone scan
- ☐ EMG
- ☐ doppler/US
- ☐ ankle brachial index

Do you currently have numbness and tingling? Yes | No

If yes, where? (Select all that apply)

- ☐ right arm
- ☐ left arm
- ☐ right leg
- ☐ left leg
- ☐ trunk/chest

Additional Comments:

Are you getting chemotherapy? Yes No

If yes, how often?

Are you having any side effects from chemotherapy? Yes No

If yes, what are they?

Date Started? Date Completed?

Have you been diagnosed with chemotherapy induced peripheral neuropathy? Yes No

If yes, are you experiencing difficulty with any of the following? (Select all that apply)

- fastening buttons
- negotiating stairs
- falling
- dressing
- walking
- other
- sleeping
- loss of balance
- typing on a keyboard
- writing
- using eating utensils

Additional Comments:

Are you getting radiation treatment? Yes No

If yes, where?

Date Started? Date Completed?

Do you use oxygen? Yes No

Amount Used?

- 1 liter
- 2 liters
- 3 liters
- 4 liters
- > 4 liters

Frequency of Use?

- intermittently
- continuously
- nightly

Have you experienced an unintended weight loss? Yes No

If yes, how many pounds and in what time period?)

Have you experienced an unintentional weight gain? Yes No

If yes, how many pounds and in what time period?

Home Environment

How would you rate your health? ○ excellent ○ good ○ fair ○ poor

Do you exercise regularly? ○ does ○ does not

How many falls have you had in the past 6 months? ○ 0 ○ 1 to 2 ○ >3

Do you use a walking aid? Yes No

If yes, what? (Select all that apply) ☐ cane ☐ walker ☐ rollater ☐ wheelchair ☐ crutches

What is your employment status? ○ employed ○ unemployed ○ retired

What do you do for a living?

Do you live alone? ○ alone ○ with someone

If you live with someone, in which setting do you live? ☐ assisted living facility ☐ nursing home ☐ group home ☐ private residence with caregiver/family

Do you require assistance at home? Yes No

Do you have stairs at home? Yes No

If yes, how many? ○ 1-8 ○ 9-15 ○ >15

Where is the railing as you go up the stairs? (Select all that apply) ☐ left ☐ right

Goals/Followup

What are your goals for therapy?

When are you scheduled to return to the doctor for follow-up? ○ as needed ○ within 1 month ○ after completion of therapy

Additional Comments: