Penrose-St. Francis Health Services
Centura Health

NCI COMMUNITY CANCER CENTERS PROGRAM

Name _____ Date _____

Date of birth _____ Age _____

Who referred you? _____

What is the main problem for which you are here? _____

Medical Problems:

1)_____
2)_____
3)_____
4)_____
5)_____

Surgeries

1)_____ Year _____
2)_____ Year _____
3)_____ Year _____
4)_____ Year _____
5)_____ Year _____

Smoking history:

Are you a smoker? (circle one): **YES** **NO** **QUIT** **NEVER SMOKED**
How old were you when you started smoking? _____
How many packs per day? _____
How old when you quit smoking _____

Alcohol Consumption:

Favorite drink? _____
How many? _____per day/week/month

Occupation: _____
Pets: _____
Allergies: _____

Have you ever lived in Arizona, Nevada, California desert, around the Mississippi River or Ohio River Valley? YES NO If so, where _____

Do your parents, children, or siblings suffer from any of the following conditions?

- Death before age 60? YES NO If YES, who? _____
  Reason for death? _____
- Asthma? YES NO If YES, who? _____
- Emphysema? YES NO If YES, who? _____
- Cancer? YES NO

If YES for cancer, who? _____What type of Cancer? _____
_____ What type of Cancer? _____
_____ What type of Cancer? _____