Patient Self-Assessment

Community Cancer Institute

1. Name:

2. Preferred contact number:

3. Have you had cancer before? If yes, what kind and when?

☐ Yes ☐ No

4. Has anyone in your family had cancer? If yes, who, what kind and when?

☐ Yes ☐ No

5. Do you smoke or use drugs: how often?

☐ Yes ☐ No

6. Who lives with you?

7. Who is available to help you throughout your cancer treatment?

8. Do you currently work? If yes, where and what do you do? If no, when did you stop working?

☐ Yes ☐ No

9. Have you recently lost or gained weight? How much and over what time frame?

☐ Lost weight ☐ Gain weight

10. Did you experience a decrease appetite over the last month?

☐ Yes ☐ No

11. Did you use supplemental drinks or tube feedings over the last month?

☐ Yes ☐ No

12. Are you experiencing pain? Where? How would you rate it between 1-10? What makes it better, what makes it worse?

☐ Yes ☐ No

13. Height:

14. Weight:

15. How are you going to get from your home to your appointments?

- [ ] Drive yourself
- [ ] Family member or loved one will drive
- [ ] Public transportation
- [ ] Medical transportation
- [ ] I don't know

Check the box of any topic you have questions, concerns, or would like more information about:

16. Health Insurance/Financial Interest:

- [ ] Insurance coverage
- [ ] Difficulty paying bills
- [ ] Financial assistance from Medicaid/Medicare
- [ ] Confusing financial paperwork
- [ ] Prescription assistance
- [ ] Medical equipment or supplies (wheelchairs, dressings)
- [ ] Citizenship/undocumented status
- [ ] Other:

17. Physical Needs:

- [ ] Child/elder care
- [ ] Housing
- [ ] Food, clothing, other physical needs
- [ ] Prostheses, wigs, etc.
- [ ] Extended care needs: home care, hospice, long-term care
- [ ] Other: