Bodymind
26 B Baltimore Avenue
Rehoboth Beach, DE 19971

CANCER HISTORY

Date of diagnosis:___________________________ Type of cancer?_______________________________
Location:_________________________________ Present status of cancer?________________________
Has the cancer spread to or affected bone/ liver/ lung/ kidneys / brain/ heart? *Yes / No*
Name of oncologist______________________________________ Date of last visit__________________

Did you have surgery? *Yes / No.* If yes, type of surgery/ date(s)_________________________________
Reconstruction? *Yes / No*
Lymph nodes removed? *Yes / No* # of nodes removed _________ Where?________________________
Has anyone talked to you about lymphedema?____

Have you had: Chemotherapy: *Yes / No* If yes, dates:____
dates: ____
Radiation: *Yes / No* If yes, # of treatments ________ Date completed:_______________
# of treatments ________ Date completed: _______________
Area(s) irradiated:____
Lymph nodes irradiated in neck, armpit, or groin? *Yes / No*

Are there any effects of cancer or cancer treatment on your blood clotting? *Yes / No*
Any *bruising / bleeding / blood clots / deep vein thrombosis*? Where?______________________________
Are there any effects of cancer or cancer treatments on your blood counts? List abnormal values for:
red blood cells: white blood cells: Platelets:

What is your energy/ activity level like?___________ Any activity restrictions?______________________

Side effects: (Circle) current conditions Underline past conditions

GI conditions: Nausea vomiting low appetite mouth sores wt. loss wt. gain diarrhea constipation
Musculoskeletal: osteoporosis bone pain adhesions incision headache touch sensitivity decreased range of motion or function pain former injuries fractures joint problems joint replacement
Nervous System: burn/ itch/ tingle/ prickle/ numbness in arms/ hands/ feet/ legs memory problems
Skin: Skin infection dry skin fragile skin skin irritation radiation skin reaction hair loss
Circulatory/ Blood: edema easy bruising low platelet low white count blood clot excessively cold/ warm lymphedema heart condition high blood pressure lung condition
General: fatigue depression anxiety allergies systemic infection infectious condition

Signature____ Date__________________