ANSCHUTZ HEALTH AND WELLNESS CENTER

Bfit Bwell
A WELLNESS STRATEGY FOR CANCER SURVIVORS

FITNESS

Medical History

1.) Name:_____ Date:_____

Current Primary Care Physician: _____

University of Colorado Cancer Center Oncologist: _____

How did you hear about us? (name and job title, if applicable): _____

DOB_____ Age_____ Gender: M F

Check ALL spaces below which apply to you. (If checked please include explanation and date of occurrence)

2.) Present Medical History *Explanation and/or date:*

__ Back/Neck Pain or Problems _____

__ Shoulder/Chest Pain or Problems _____

__ Foot/Ankle Pain or Problems _____

__ Knee/Hip Pain or Problems _____

__ Arthritis _____

__ Swollen/Stiff/Painful Joints _____

__ Lymph node involvement? Y N Lymphedema or at risk for Lymphedema?_____

__ Changes in Sensation _____

__ Changes in Balance or Balance Problems _____

__ Stroke _____

__ Nausea or Vomiting_____

__ Anemia _____

__ Fallen in last 6 weeks? __ Feel this was related to cancer or treatment?

Describe: _____

WELLNESS CHANGES EVERYTHING

___ Increased Anxiety/Depression _____

___ Epilepsy _____

___ Vision/Hearing Problems _____

___ Breathing Problems_____

___ Other_____

Past Operations: (starting with the most recent)

1.) _____Date:_____

2.) _____Date:_____

3.) _____Date:_____

4.) _____Date:_____

5.) _____Date:_____

Hospitalizations (if any): (reason) _____

3.) Current Cancer Treatment

Current Cancer Diagnosis: _____

Date of Diagnosis: _____

a.) Are you currently receiving, or plan to receive, chemotherapy? **Y / N**

Type:

Description (dosage, schedule, etc. If known):

b.) Are you currently receiving, or plan to receive, radiation therapy? **Y / N**

Description:

c.) Do you have a surgery planned? **Y / N**
Description:

d.) Are you currently receiving, or plan to receive, other cancer related treatments? **Y / N**
Description:

4.) Past Cancer Treatment (answer to best of your ability)

Past Cancer Diagnoses (with date of diagnosis):

In the past 6 months:

a.) Did you receive chemotherapy? **Y / N**
Type:
Description (date, dosage, schedule, etc. If known):

b.) Did you receive radiation therapy? **Y / N**
Description:

c.) Did you have surgery? **Y / N**
Description:

d.) Did you receive other cancer related treatments? **Y / N**
Description:

Please briefly describe other cancer related treatments you may have received over 6 months ago (use back of page if necessary).

5.) Medications

Please list all current medications: (Or print a list and attach)

Medication:	Dosage:	Date Started: