HEALTHY LIVING PROGRAM
PARTICIPANT HEALTH HISTORY

Wellness House for LIVING with CANCER
You'll feel better inside.

PARTICIPANT INFORMATION

Name _____ Date _____/_____/_____

Phone _____ Email _____ Date of Birth _____/_____/_____

Emergency Contact Name _____ Relationship _____ Phone _____

MEDICAL TEAM

Primary Care Physician _____ Date of last visit: _____/_____/_____

Primary Oncologist _____ Date of last visit: _____/_____/_____

Other Specialist _____ Date of last visit: _____/_____/_____

CANCER HISTORY & TREATMENT

Type of Cancer & Location _____ Stage of Diagnosis: ☐ 0 ☐ I ☐ II ☐ III ☐ IV

Date of Diagnosis _____/_____/_____ Has Cancer Recurred: ☐ No ☐ Yes Date _____/_____/_____

Has Cancer Spread: ☐ No ☐ Yes Date _____/_____/_____ Location(s) _____

1. What type(s) of **cancer treatments** have you received, are currently receiving or will you receive in the future?

	None	Current	Future Date	Completed Date	Name/Details	Persistent Side Effects
Surgery:	☐	☐	__/__/__	__/__/__		
Chemotherapy:	☐	☐	__/__/__	__/__/__		
Radiation:	☐	☐	__/__/__	__/__/__		
Medication:	☐	☐	__/__/__	__/__/__		

MEDICAL HISTORY

1. Check ALL spaces below that apply to you. Please include an explanation/date of occurrence and indicate if you have any of the following as a result of cancer/treatment.

Symptom	Explanation/Date	Cancer Related	Symptom	Explanation/Date	Cancer Related
☐ Fatigue		☐	☐ Shortness of Breath		☐
☐ Depression		☐	☐ Muscle Weakness		☐
☐ Anxiety		☐	☐ Fractures		☐
☐ Sleep Issues		☐	☐ Lymphedema		☐
☐ Weight Change		☐	☐ Neuropathy		☐
☐ Appetite Change		☐	☐ Edema		☐
☐ Joint Issues		☐	☐ Other		☐
☐ Pain		☐	☐ Other		☐

2. List all current medications not related to cancer treatment

Medication	Prescribed for	Dosage	Date started

3. Please list any additional medical concerns or complications:

_____

_____

_____

CARDIOVASCULAR RISK STRATIFICATION

Please check the appropriate box, if you have experienced any of the following:

☐ Heart attack ☐ Coronary angioplasty (PTCA) ☐ Heart transplantation
☐ Heart surgery ☐ Heart valve disease ☐ Congenital heart disease
☐ Cardiac catheterization ☐ Heart failure
☐ Pacemaker/implantable cardiac defibrillator/rhythm disturbance
☐ You experience chest discomfort with exertion ☐ You experience dizziness, fainting or blackouts
☐ You experience unreasonable breathlessness ☐ You take heart medication
☐ You have diabetes ☐ You have concerns about the safety of exercise
☐ You have asthma or other lung disease ☐ You take prescription medications
☐ You have burning or cramping sensation in your lower legs when walking short distances
☐ You have musculoskeletal problems that limit your physical activity
☐ You are pregnant

☐ You are a man older than 45 years ☐ You are > 20 pounds overweight
☐ You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal
☐ You smoke, or quit smoking in the previous 6 months ☐ You take blood pressure medication
☐ Your blood cholesterol level is > 200 mg/dL ☐ You do not know your cholesterol level
☐ You have a blood relative who had a heart attack or heart surgery before age 55 (father/brother) or age 65 (mother/sister)
☐ You are physically inactive (i.e., you get < 30 minutes of physical activity on at least 3 days/week)

☐ **NONE OF THE ABOVE**

LIFESTYLE & ACTIVITY EVALUATION

1. Do you have difficulty performing any of the following activities?
   ☐ Opening jars/doorknobs ☐ Clasping clothing ☐ Making a bed ☐ Driving ☐ Routine yard work
   ☐ Putting groceries/dishes away ☐ Carrying groceries/laundry ☐ Walking up/down stairs ☐ Lifting children
   ☐ Removing laundry from washer/dryer ☐ Other _____
2. If you answered yes to any of the above:
   a. Did the difficulty begin before or after treatment for cancer? _____
   b. If known, explain the cause of the difficulty _____
3. How many days per week do you exercise regularly? _____
4. What exercises do you participate in regularly? _____

5. How many minutes do you spend exercising at one time? _____

6. Would you consider your exercise to be (check one): ☐ light ☐ moderate ☐ vigorous

7. What physical activities do you enjoy most? _____

8. What is your main goal related to starting an exercise program? _____

_____

9. Do you anticipate any barriers to starting an exercise program?
   ☐ Lack of time ☐ Lack of enjoyment from exercise ☐ Lack of self-discipline ☐ Lack of equipment
   ☐ Weather ☐ Fatigue or feeling unwell ☐ Other _____

10. Do you have any specific cancer-related concerns about exercise?
    ☐ Type of exercise that is safe during or following cancer treatment ☐ Risk of developing lymphedema
    ☐ Risk of infection at the fitness center or public facilities ☐ Other (specify): _____
    ☐ Knowledge of fitness staff related to working with cancer survivors _____

FATIGUE INVENTORY

For each of the following, circle the one number that best indicates how that item applies to you.

1. Rate your level of fatigue on the day you felt most fatigued during the past week

Not at all Fatigued 0 1 2 3 4 5 6 7 8 9 10 As fatigued as I could be

2. Rate your level of fatigue on the day you felt least fatigued during the past week

Not at all Fatigued 0 1 2 3 4 5 6 7 8 9 10 As fatigued as I could be

3. Rate your level of fatigue on the average during the past week

Not at all Fatigued 0 1 2 3 4 5 6 7 8 9 10 As fatigued as I could be

4. Rate your level of fatigue right now

Not at all Fatigued 0 1 2 3 4 5 6 7 8 9 10 As fatigued as I could be

5. Rate how much, in the past week, fatigue interfered with your general level of activity

No Interference 0 1 2 3 4 5 6 7 8 9 10 Extreme Interference

6. Rate how much, in the past week, fatigue interfered with your ability to bathe and dress yourself

No Interference 0 1 2 3 4 5 6 7 8 9 10 Extreme Interference

7. Rate how much, in the past week, fatigue interfered with your normal work activity (includes both work outside the home & housework)

No Interference 0 1 2 3 4 5 6 7 8 9 10 Extreme Interference

8. Rate how much in the past week, fatigue interfered with your ability to concentrate

No Interference 0 1 2 3 4 5 6 7 8 9 10 Extreme Interference

9. Rate how much, in the past week, fatigue interfered with your relations with other people

No Interference 0 1 2 3 4 5 6 7 8 9 10 Extreme Interference

10. Rate how much in the past week, fatigue interfered with your enjoyment of life

No Interference 0 1 2 3 4 5 6 7 8 9 10 Extreme Interference

11. Rate how much, in the past week, fatigue interfered with your mood

No Interference 0 1 2 3 4 5 6 7 8 9 10 Extreme Interference

12. Indicate how many days, in the past week, you felt fatigued for any part of the day

Days 0 1 2 3 4 5 6 7 Days

13. Rate how much of the day, on average, you felt fatigued in the past week

None of the Day 0 1 2 3 4 5 6 7 8 9 10 The Entire Day

14. Indicate which of the following best describes the daily pattern of your fatigue in the past week

0	1	2	3	4
Not at all fatigued	Worse in the morning	Worse in the afternoon	Worse in the evening	No consistent daily pattern of fatigue