Oncology History Form

Name:____ DOB:______________________

When were you first diagnosed with cancer?______________ Is cancer currently active? Yes or No

What type of cancer?________________________ Where was/is it located?______________________

What kind of activities are you able to participate in? Please give a general idea of your current day-to-day activities, if any.____
____
____
____

Are you being treated now? Yes or No

What treatments have you undergone and when? Please list dates and types of surgeries and other treatments.____
____
____
____
____

Did your treatment include any removal or radiation of lymph nodes? Yes or No

If yes, please describe where.____

Did your treatment include radiation therapy? Yes or No

If yes, please describe where.____

Do you have any **site** restrictions due to the following? Mark “Y” for yes to all that apply.

____ Incisions, open wounds, drains, or dressings
____ Tumor site
____ Radiation site
____ Fracture history
____ History/risk of blood clot
____ Skin sensitivity, rash, or skin condition
____ IV, port, ostomy, catheter, or other device
____ Neuropathy
____ Bone or spine metastasis
____ Area of infection
____ Other (please describe):________________
____

Do you have any **pressure** restrictions due to the following? Mark “Y” for yes to all that apply.

____ History or risk of lymphedema
____ Low platelet count
____ Steroid medication
____ Fragile veins
____ Fatigue
____ Infection or fever
____ Anticoagulants
____ Bone or spine metastasis
____ Fragile/sensitive skin
____ Area of pain or burning
____ Recent surgery
____ Other (please describe):________________
____

Do you have any **position** restrictions due to the following? Mark “Y” for yes to all that apply.

____ Incision
____ Medication
____ Ostomy
____ Tumor site
____ Difficulty breathing
____ Tender skin
____ Swelling, or risk of swelling (does any body area need elevating?) If Yes, where?____________________
____ Medical devices; if Yes, where?____
____ Discomfort; if Yes, where?____

Has cancer, or cancer treatment, affected any of the following functions in your body? Mark “Y” for yes to all that apply.

____ Lungs
____ Liver
____ Heart
____ Kidney
____ Blood counts
____ Nervous system
____ Energy level

If you marked Yes to any of the areas above, please describe here:______________________________

Do you have any swelling or tendency to swell anywhere in your body? Yes or No

If yes, please describe.____

Do you have any sites of pain or tenderness anywhere in your body? Yes or No

If yes, please describe.____

Do you have any sites of numbness or reduced sensation anywhere in your body? Yes or No

If yes, please describe.____

Are there any other conditions, side-effects, diagnoses, etc. that are not listed above? Yes or No

If yes, please describe.____

Is there anything else you would like me to know to better ensure a comfortable, worry-free, and relaxing massage?____