NEW PATIENT ONCOLOGY ASSESSMENTFORM

MINISTRY OF HEALTH

NEW PATIENT ONCOLOGY ASSESSMENT FORM

Facility Name_____

Patient Bio-data Date: _____

Patient Name (3 names): _____ ID No: _____

Date of Birth: _____ Age in years: _____Sex_____

Mobile Phone: _____

Address: _____ City:

_____

Place of Birth: _____ Next of Kin name _____

Next of Kin relationship_____ Next of Kin phone_____

Marital Status: _____ Number of Children: _____

Highest level of Education (tick): Primary ☐

Secondary ☐

Tertiary ☐

Mode of payment: Cash ☐

NHIF ☐

Other Insurance ☐ (Specify) _____

Referring Physician and Facility

Name: _____ Phone No:_____

Facility: _____

Vital Data

Blood Pressure…….. Pulse rate……

Weight (kg)……Height (cm)……BSA (m^2)…….....

Current clinical history and findings

1. Presenting complaints

   _____

   _____

   _____

2. Do you currently use tobacco? [ ] Yes [ ] No
   If yes, for how long (years)? _____
   If No, have you ever used tobacco in the past? [ ] Yes [ ] No
3. Do you currently drink alcohol? [ ] Yes [ ] No
   If yes, for how long (years)? _____
4. What other medications are you on?

   _____
5. Do you have other disease conditions?

   _____
6. HIV status _____
7. Do you have any food or drug allergies? List those known

   _____
8. Are you using alternative/complimentary therapy to assist you to control your cancer?
   [ ] Yes [ ] No
   If yes, which ones?

   _____
9. Do you have any family history of cancer? [ ] Yes [ ] No
   If yes, list as shown below.

Cancer diagnosed (if known)	**Relative affected**

Female patients: LMP_____Gravid? [ ] Yes [ ] No

History of contraception: [ ] Yes [ ] No

Current method of contraception _____

Fertility counseling done? [ ] Yes [ ] No

Past Medical History

Please list all major illnesses and surgeries for which you have had or been treated (starting with the most recent):

1._____
2._____
3._____
4._____
5._____

Previous cancer treatment given

Treatment Modality	**Treatment details**	**Date given**
Chemotherapy		
Hormonal therapy		
Radiotherapy		
Surgery		
Targeted therapy		
Others (specify)		

Physical Examination findings

_____
_____
_____
_____

Diagnostic and Staging Information

Histopathological Diagnosis (attach copy of the histology report)

_____

Stage _____

Pathology Number_____Date reported _____

Other Diagnostic Information: Tumour markers, imaging, immunohistochemistry

_____

_____

_____

Radiological findings

_____

_____

Psychosocial assessment

_____

_____

Pain assessment (refer to pain assessment form)

_____

_____

Any other examinations (specify)

_____

_____

Treatment plan (as agreed upon by the multidisciplinary team)

Indicate treatment goal: [ ] Curative [ ] Palliative

If curative: [ ] Neoadjuvant then surgery

[ ] Surgery then adjuvant

Radiotherapy regimen prescribed: _____

Chemotherapy regimen prescribed

Hormonal therapy regimen
prescribed:_____

Other (specify) _____

Follow-up plan _____

Doctor's name _____

Sign_____ Date _____