Oncology Massage

(Must accompany a complete health history)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When were you diagnosed? \_\_\_\_\_\_\_\_\_\_\_\_ Type of Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where was it located? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Present Stats of Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your oncologist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you see your oncologist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery/ Procedure Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

Lymph nodes removed: Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reconstruction: Date(s)/ Procedure(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side Effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chemotherapy:

Number of Treatments: \_\_\_\_\_\_\_\_ Beginning Date: \_\_\_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_

Number of Treatments: \_\_\_\_\_\_\_\_ Beginning Date: \_\_\_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_

Number of Treatments: \_\_\_\_\_\_\_\_ Beginning Date: \_\_\_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_

Side Effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Radiation:

Number of Treatments: \_\_\_\_\_\_\_\_ Beginning Date: \_\_\_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_

Area of Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nodes Irradiated in the neck, armpit, or groin? Yes No

Number of Treatments: \_\_\_\_\_\_\_\_ Beginning Date: \_\_\_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_

Area of Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nodes Irradiated in the neck, armpit, or groin? Yes No

Side Effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: Please list any other treatments or medications:

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Has any doctor said anything to you about lymphedema? Yes No Bone Metastases? Yes No

Medical Devices: Feeding Tube (PEG) IV Catheter Port Breast Expander Breast Prosthesis Urinary Catheter Ostomy Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side Effects:

Circle current conditions

Underline past conditions

\_\_\_\_ Check here if explanation below

**GI Conditions:**

nausea vomiting low appetite mouth sores wt. loss wt. gain diarrhea constipation

**Musculoskeletal:**

osteoporosis bone pain adhesions incision headache touch/pressure sensitivity

decreased range of motion/function pain former injuries fractures joint problems

joint replacements

**Nervous System:**

burn, itch, tingle, prickle, numbness in arms, hands, leg, and feet 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

**Other:**

current tumor enlarged nodes, spleen, liver radioactivity other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:**

Drug Name Purpose Side Effects

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