

## PATIENT WITH HISTORY OF CANCER

Date \_\_\_\_\_

Patient name \_\_\_\_\_

MD Anderson ID# \_\_\_\_\_

What kind of cancer? \_\_\_\_\_

Where was the primary site of cancer? \_\_\_\_\_

When was cancer detected? \_\_\_\_\_ By whom? \_\_\_\_\_

Did you have surgery? yes/no Doctor \_\_\_\_\_ When \_\_\_\_\_

Did you receive radiation therapy? Yes/no Doctor \_\_\_\_\_ When \_\_\_\_\_

Did you receive chemotherapy yes/no Doctor \_\_\_\_\_  
When? \_\_\_\_\_

Bone marrow transplant yes/no \_\_\_\_\_

Current Oncologist \_\_\_\_\_ phone \_\_\_\_\_

Check up schedule \_\_\_\_\_

### Prior to cancer detection

Did you see the dentist regularly yes/no

Last work done before cancer detection \_\_\_\_\_

### After cancer detection before cancer therapy did you have any dentistry done?

yes/no describe \_\_\_\_\_

Please circle current problems/concerns

dry mouth \_\_\_\_\_ medications \_\_\_\_\_

sore mouth \_\_\_\_\_ medications \_\_\_\_\_

mouth infections \_\_\_\_\_ medications \_\_\_\_\_

difficulty opening / difficulty swallowing

missing teeth / difficulty chewing food

pain/ sensitivity describe \_\_\_\_\_

medications \_\_\_\_\_

speaking

acid reflux \_\_\_\_\_ medications \_\_\_\_\_

current home dental care & oral medications \_\_\_\_\_

currently smoking yes/no

history of antibiotic resistant infection yes/no

how treated

history of jaw bone exposure yes/no

### Are you taking or have you ever taken these types of medications?

**Bisphosphonates: Aredia, Zometa, Fosamax or Boniva Yes No**

Doctor's office notes

Field of XRT \_\_\_\_\_

Amount of gray \_\_\_\_\_

Misc notes \_\_\_\_\_