BC CANCER
Provincial Health Services Authority

Patient-Reported Information & Symptom Measurement (PRISM)

Please answer the following questions to help us get to know you better. Your answers will help us provide you with the best care possible. This information will become part of your health record and will be available to your health care team.

Please feel free to leave any questions blank that you do not wish to answer.

Completed by: ☐ Patient ☐ Caregiver ☐ Nurse Other _____ Date _____

General Information

1. What gender do you identify with?

   ☐ Female ☐ Male ☐ Transgender – woman ☐ Transgender – man ☐ Other

2. What is your sexual orientation?

   ☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Queer ☐ Other ☐ Not sure

3. a) Do you identify as an indigenous person? ☐ No ☐ Yes

   If yes, are you (please check) ☐ First Nations ☐ Metis ☐ Inuit

   Do you currently reside on your traditional territory? ☐ No ☐ Yes

   b) If no, to which ethnic or cultural group do you belong?

   ☐ White
   ☐ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc)
   ☐ Chinese
   ☐ Black
   ☐ Filipino
   ☐ Latin American
   ☐ Arab
   ☐ Southeast Asian (e.g., Vietnamese, Cambodian, Laotian, Thai, etc)
   ☐ West Asian (e.g., Iranian, Afghan, etc)
   ☐ Korean
   ☐ Japanese
   ☐ Other

   c) Which is your preferred language? _____

   d) Do you have any personal/cultural/ethnic/religious background that we need to know and respect? ☐ No ☐ Yes; please specify: _____

   _____

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Medical Information

4. What is your marital status?

   ☐ Single ☐ Married/Common-law/Living with Partner ☐ Divorced/Separated

   ☐ Widowed ☐ Living alone ☐ Living with support person

5. Do you have dependents (children or adults) living at home with you? ☐ No ☐ Yes

6. Are you currently employed? ☐ No ☐ Yes ☐ Self-employed

7. What is/was your occupation? _____

8. Do you have a drug plan that helps to pay for medication?

   ☐ No ☐ Yes ☐ Don't know

9. Are you receiving one or both of these professional services at home?

   ☐ Homemaking Services ☐ Home Care Nursing

10. Do you have any issues regarding transportation to the cancer centre? ☐ No ☐ Yes

11. Do you have a family (blood relatives) history of cancer? ☐ No ☐ Yes ☐ Don't know

    If you have a family history of cancer, please list who in your family has or had cancer and the type of cancer:

Family Member	Type of Cancer

12. Do you have any allergies? ☐ No ☐ Yes ☐ Don't know

    If yes, please indicate the type of allergy you have and your reaction to the allergy in the table below:

Allergy (for example: medication, latex, other)	Reaction

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Medical Information

13. Please indicate if you have or had any of the following (please check all that apply):

Heart & Vascular:

- ☐ Heart problems, e.g. heart attacks, abnormal heart rate
- ☐ High blood pressure
- ☐ Blood clots
- ☐ Stroke
- ☐ Implanted electronic/ magnetic device, e.g. pacemaker, neurostimulator, insulin pump, defibrillator

Lung:

- ☐ Asthma/emphysema/COPD
- ☐ Tuberculosis (TB)

Kidney:

- ☐ Kidney disease
- ☐ Dialysis

Liver:

- ☐ Hepatitis
- ☐ Cirrhosis

Mental Health:

- ☐ Depression
- ☐ Anxiety
- ☐ Claustrophobia
- ☐ Other, please specify mental health concerns:

_____

_____

_____

_____

Joints & Muscles:

- ☐ Arthritis
- ☐ Connective tissue disorder, e.g. Lupus, Scleroderma
- ☐ Joint replacement

General:

- ☐ Menopause: age when your menstrual period stopped_____
- Number of pregnancies: ___
- Number of live births: _____
- ☐ Currently pregnant
  Date of last menstrual period:_____
- ☐ Diabetes
- ☐ HIV/AIDS

- ☐ Other cancer diagnosis:

  _____

- ☐ Previous radiation therapy:

  _____

- ☐ Past operations, please list:

  _____

  _____

- ☐ Other:

  _____

  _____

  _____

  _____

  _____

  _____

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14. Have you ever been told you had a multi-resistant organism, drug resistant organism, MRSA, VRE, CRE, or "Super Bug"? ☐ Don't know ☐ No ☐ Yes

15. Please circle the number that best describes your level of activity:

0	Usual activity – no problem
1	Mild – able to continue normal activity
2	Change in normal activity – bed rest less than 50% waking hours
3	In bed/chair more than 50% waking hours
4	Bed/chair ridden or unable to care for self

16. Do you have any balance/muscle weakness problems? ☐ No ☐ Yes

17. Have you fallen in the last 6 months? ☐ No ☐ Yes

18. Do you use a cane, walker or wheelchair? ☐ No ☐ Yes

19. Have you ever smoked tobacco? ☐ No ☐ Yes

If yes,

a) How long has it been since you last smoked a cigarette (even one or two puffs)
   - ☐ I smoked today
   - ☐ 1-7 days (number of days since last cigarette) ____
   - ☐ Less than one month (number of weeks since last cigarette)____
   - ☐ Less than one year (number of months since last cigarette) ____
   - ☐ More than one year (number of years since last cigarette) _____

b) How old were you when you started smoking regularly? ____ years old

c) On average, how many cigarettes do you or did you smoke per day? _____

d) How soon after you wake up do you or did you usually smoke your first cigarette of the day?
   ☐ Within the first hour ☐ Usually after the first hour

20. Do you currently smoke other products or chew tobacco? ☐ No ☐ Yes
If yes, please describe: _____

21. Do you use Cannabis products in any form? ☐ No ☐ Yes
If yes, please describe: _____

22. Do you use recreational/street drugs other than Cannabis? ☐ No ☐Yes
If yes, please describe: _____

23. Do you drink beer, wine or other alcoholic beverages? ☐ No ☐ Yes
If yes, how many drinks would you have in a week? _____

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Wishes or Plans for Health Care

Advance Care Planning is a process by which adults talk over their beliefs, values and wishes for health care with their close family/friend(s) and health care providers in advance of a time when they may not be able to decide for themselves.

1) I know about Advance Care Planning:

☐ No ☐ Yes ☐ Not Sure

2) If yes, do you have wishes and plans for your health care written down?

☐ No ☐ Yes* ☐ Not Sure

* If yes, please share a copy with us so that we can understand your wishes and instructions.

3) If you answered no to question 2, would you like to discuss this with someone on the healthcare team?

☐ No ☐ Yes ☐ Not Sure

4) I would like more information about Advance Care Planning.

☐ No ☐ Yes ☐ Not Sure

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Symptom Self Assessment

Please circle the number that best describes how you feel NOW:

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
No tiredness (*Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
No drowsiness (*Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
No nausea	0	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
No lack of appetite	0	1	2	3	4	5	6	7	8	9	10	Worst possible lack of appetite
No shortness of breath	0	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
No depression	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
No anxiety (*Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
Best feeling of wellbeing (*Wellbeing =how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst possible wellbeing
No _____ other problem (*for example, constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst possible _____

* Adapted from the **Edmonton Symptom Assessment System (ESAS)** with permission

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PSSCAN-R Psychological Screening

Please answer the following questions to help us learn more about your well being. A serious illness can affect the quality of your life in many ways. We may contact you to offer our counselling services based on the information you provide to us, or contact you regarding opportunities to participate in research.

Part A:
Please respond to each question with "Yes" or "No" by making a circle around the appropriate answer. There are no right or wrong answers.

1.	Do you live alone?	No	Yes
2.	When you need help, can you count on anyone to help with daily tasks such as grocery shopping, cooking, giving you a ride?	No	Yes
3.	Do you have regular contact with friends or relatives?	No	Yes
4.	Have you lost your life partner within the last few years?	No	Yes
5.	Can you count on anyone to provide you with emotional support?	No	Yes

Part B:
Please check all of the following items that have been of concern or a problem for you in the past week including today.*

6. **Emotional:** ○ Fears/Worries ○ Sadness ○ Frustration/Anger ○ Changes in appearance ○ Intimacy/Sexuality	7. **Informational:** ○ Understanding my illness/treatment ○ Talking with the health care team ○ Making treatment decisions ○ Knowing about available resources
8. **Practical:** ○ Work/School ○ Finances ○ Getting to & from appointments ○ Accommodation	9. **Spiritual:** ○ Meaning/Purpose of life ○ Faith
10. **Social/Family:** ○ Feeling a burden to others ○ Worry about family/friends ○ Feeling alone	11. **Physical:** ○ Concentration/Memory ○ Sleep ○ Weight

Other concerns, please specify: _____

*** Canadian Problem Checklist** developed by the Canadian Partnership Against Cancer, August 2010.

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Part C: Please place an 'X' in the box that best describes what you have experienced.

	Not at all	A little bit	Moderately	Quite a bit	Very much
12. **During the past week** I have felt my heart race and I tremble.					
13. **During the past week** I have felt that I cannot control anything.					
14. **During the past week** I have lost interest in things I usually cared for or enjoyed.					
15. **During the past week** I have felt nervous and shaky inside.					
16. **During the past week** I have felt tense and cannot relax.					
17. **During the past week** my thoughts are repetitive and full of scary things.					
18. **During the past week** I have felt restless and find it difficult to sit still.					
19. **I have *recently*** thought about taking my life. **NOTE: If you have, please speak with a member of your health care team and/or your family doctor today.**					
20. **In the past year,** I have had 2 weeks or during which I felt sad, blue or depressed.					
21. **I have had 2 years or more in my life** when I felt depressed or sad most days even if I felt okay sometimes.					

Thank you for taking the time to respond to this form.

If you or your family is currently struggling with the stress of your diagnosis, information and support is available on our website: www.bccancer.bc.ca/PPI/copingwithcancer or by calling:
BC Cancer Patient & Family Counselling Departments

Abbotsford Centre	604.851.4733
Sindi Ahluwalia Hawkins Centre for the Southern Interior	250.712.3963
Centre for the North	250.645.7330
Fraser Valley Centre	604.930.4000
Vancouver Centre	604.877.6000 x 672194
Vancouver Island Centre	250.519.5525

Patient and Family Counselling Documentation:

D = _____ A = _____
Comments: _____
Reviewed by: _____
Date: _____

Revised April 2014 Review April 16, 2012

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Nutrition Screening Tool

Today's Date: _____

1. What is your current weight?_____ pounds (or_____ kilograms)

   How tall are you? _____

2. Have you lost weight recently without trying?

   ☐ No **(If NO, please go to question 3)**

   ☐ Yes

   ☐ Unsure

   If YES, how much weight have you lost?

   ☐ 2-13 lbs (1)

   ☐ 14-23 lbs (2)

   ☐ 24-33 lbs (3)

   ☐ More than 33 lbs (4)

   ☐ Unsure (2)

   Over what time period have you lost this weight?

   ☐ Over the past two weeks

   ☐ Over the past month

   ☐ Over the past six months or more

   Are you still losing weight? _____ ☐ No ☐ Yes ☐ Unsure

3. Have you been eating poorly because of a decreased appetite? ☐ No (0) ☐ Yes (1)

   If YES, how much are you eating now?

   ☐ about 75% of my usual amount

   ☐ about 50% of my usual amount

   ☐ about 25% of my usual amount

4. Are you having problems chewing food? ☐ No ☐ Yes

5. Are you having problems swallowing food? ☐ No ☐ Yes

6. Are you having 3 or more watery bowel movements per day? ☐ No ☐ Yes

For Health Professional Use: