

Initial Childhood Cancer Inquiry Report Form (0-17 years of age)

1. Name of Pediatric Patient (age 0-17): _____
2. Name of person providing information: _____
3. Relationship to the patient: _____
4. Date of birth of the patient: ____/____/____
5. Age at last birthday: ____
6. Address of patient: _____

7. Length of residence in community: _____
8. Patient's gender: _____ Male _____ Female
9. Patient's race: _____ Ethnicity: Hispanic? _____ Yes _____ No
10. Type of cancer (please specify the original cell type and body organ(s) affected):

11. Date of diagnosis (month and year): _____
12. Name & telephone of primary physician: _____

13. Please list any other major health problems the patient has had (include major illnesses, long term conditions, sensitivities, etc.):

14. Work history of the patient's father (please include the occupation, industry and length of employment for each major job--begin with the current or most recent job):

15. Work history of the patient's mother (please include the occupation, industry and length of employment for each major job--begin with the current or most recent job):

16. If other first degree family members have had cancer, please list their relation to the patient and the type of cancer (include parents, grandparents, siblings, aunts and uncles):

17. Does the patient presently smoke tobacco, or has the patient smoked tobacco in the past?
_____ No _____ Yes: Number of years of smoking: _____

18. Is there anyone in the household who presently smokes tobacco, or has smoked during the patient's lifetime?

_____ No _____ Yes: Number of people who smoke or smoked: _____

19. What is the source of drinking water for the patient's residence? _____

20. Please list major hobbies that are practiced in the patient's house by any family member:

21. If you have any thoughts about what may have caused/contributed to the cancer, please list them.

Thank you for taking the time to complete this form. If there is any other information you think is relevant, please include it on an additional sheet of paper. Please mail the completed form to:

Oregon State Cancer Registry (OSCaR)
800 NE Oregon Street, Suite 730
Portland, Oregon 97232
Tel: (971)673-0986
Fax: (971)673-0996
TDD-Nonvoice(971)673-0372
Email: OSCaR.ohd@state.or.us
Web: www.healthoregon.org/oscar

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