INTAKE FORM - NECK MASS

Name: _____ DOB (dd/mm/yyyy): _____

How long has the lump/mass been there?: _____

How was it detected (i.e. ultrasound, physical exam)?: _____

Is it painful?: _____

Has there been any change in the size or number of lump(s)?: _____

Do you have, or have you had any of the following symptoms? (please check if yes):

- ☐ Recurrent throat infections
- ☐ Frequent sore throat
- ☐ Toothache
- ☐ Fatigue
- ☐ Swollen/sore lymph nodes
- ☐ Fevers
- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Trouble swallowing
- ☐ Trouble breathing
- ☐ Trouble speaking / hoarseness
- ☐ Ear pain

Have you had recurrent throat infections, such as colds or strep throat? _____

Has anyone in your family had something similar? : _____

Have you ever had any kind of cancer? If yes, what kind?: _____

Have you had any imaging for this mass (e.g. ultrasound, CT, MRI)?: _____

Have you had a biopsy of the mass?: _____

Have you received any treatments for the mass (e.g. antibiotics)?: _____

Do you have a history of radiation exposure (e.g. radiation therapy, occupation in nuclear energy)?: _____

Have you ever had head or neck surgery?: _____

Do you smoke cigarettes or use chewing tobacco?: _____

- If not, did you used to smoke?: _____
    - If you used to smoke:
    - When did you quit?: _____
    - How many years did you smoke for?: _____
    - How many packs of cigarettes per day?: _____

Do you drink alcohol?: _____ If yes, how much?: _____