

MEDICAL ONCOLOGY PATIENT HISTORY

Primary MD _____
 Phone# _____
 Fax # _____

NAME _____
 DOB _____ PHONE NO (____) _____
 ADDRESS _____

RELIGION (Optional) _____ MARITAL STATUS: Single Married Divorced Widow/
 OCCUPATION _____ PREVIOUS OCCUPATIONS _____
 OCCUPATION OF SPOUSE _____

LIST ALL STATES OR COUNTRIES WHICH YOU HAVE LIVED IN _____
 EDUCATION: Please circle the last grade completed GRADE 5 6 7 8 HIGH 1 2 3 4 COLLEGE 1 2 3 4
 REASON FOR TODAY'S APPOINTMENT _____

WERE YOU REFERRED TO THE CLINIC? Yes No IF SO, BY WHOM? _____
 ARE THERE ANY CULTURAL NEEDS THAT AFFECT YOUR HEALTHCARE? Yes No PRIMARY LANGUAGE _____

Do you have an Advanced Directive ? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, may we have a copy? YES <input type="checkbox"/> NO <input type="checkbox"/> If no, would you like more information? YES <input type="checkbox"/> NO <input type="checkbox"/>	PHYSICIAN ONLY Advanced Directive issues discussed with patient.
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PERSONAL HISTORY (PLEASE CIRCLE YES OR NO)

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Migraine Headaches	Yes	No	Gallbladder Disease	Yes	No
Stroke or Paralysis	Yes	No	Diverticulosis	Yes	No
Seizures or Epilepsy	Yes	No	Kidney Stones/Kidney Failure	Yes	No
Pneumonia or Pleurisy	Yes	No	Bright's Disease	Yes	No
Tuberculosis	Yes	No	Kidney/Urinary Tract Infection	Yes	No
Asthma	Yes	No	HIV Infection	Yes	No
Hives or Eczema	Yes	No	Arthritis or Rheumatism	Yes	No
Heart Attack	Yes	No	Bursitis, Sciatica, Lumbago	Yes	No
Angina	Yes	No	Anemia	Yes	No
Heart Failure	Yes	No	Unusual Bleeding or Bruising	Yes	No
Rheumatic Fever or Heart Murmur	Yes	No	Radiation Therapy/Chemotherapy	Yes	No
High Blood Pressure	Yes	No	Cancer (Type _____) Yes	No	
High Cholesterol	Yes	No	Nervous Breakdown	Yes	No
Diabetes	Yes	No	Severe Depression	Yes	No
Thyroid Disease	Yes	No	Frequent Infections	Yes	No
Hiatal Hernia or Reflux	Yes	No	Any Other Disease (Type _____) Yes	No	
Ulcers (stomach or intestinal)	Yes	No	If yes please list: _____		
Hepatitis or Jaundice	Yes	No			

FAMILY HISTORY	AGE IF LIVING/ HEALTH	AGE AT DEATH/ CAUSE OF DEATH	HAS ANY BLOOD RELATIVE EVERY HAD	
FATHER:			CANCER	YES NO
MOTHER:			TUBERCULOSIS	YES NO
BROTHERS OR SISTERS:			DIABETES	YES NO
			HEART DISEASE	YES NO
			HIGH BLOOD PRESSURE	YES NO
			STROKE	YES NO
			EPILEPSY	YES NO
HUSBAND/WIFE			MENTAL ILLNESS	YES NO
SON/DAUGHTER			SUICIDE	YES NO
			THYROID	YES NO
			ALCOHOLISM	YES NO
			LUPUS	YES NO
			OTHER ILLNESS	YES NO

PLEASE LIST IMMEDIATE FAMILY MEMBERS WHO HAVE OR HAVE HAD CANCER OR A BLOOD DISORDER.

<u>FAMILY MEMBER</u>	<u>CANCER/BLOOD DISORDER</u>	<u>FAMILY MEMBER</u>	<u>CANCER/BLOOD DISORDER</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

NAME _____ DOB _____ Primary MD _____
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SURGERY:

HOSPITALIZATIONS OTHER THAN SURGERY:

HAVE YOU EVER HAD A BLEEDING COMPLICATION DOSE FROM A SURGICAL PROCEDURE: Yes No

HAVE YOU EVER BEEN IMMUNIZED FOR (CIRCLE YES/NO)

Flu Vaccine Yes No When? _____
 Pneumonia Vaccine Yes No When? _____
 Zoster Vaccine Yes No When? _____
 Have you had a skin
 test for TB (Tuberculosis) Yes No When? _____

HAVE YOU EVER HAD BLOOD OR PLASMA TRANSFUSION?

Yes No **HOW MANY TIMES** _____

WEIGHT NOW: _____

ONE YEAR AGO: _____

MAXIMUM: _____

ALLERGIES: (ARE YOU ALLERGIC TO)

Penicillin or Keflex	Yes	No
Sulfa	Yes	No
Erythromycin or Tetracycline	Yes	No
Levaquin or Cipro	Yes	No
Any other antibiotics	Yes	No
If yes please list _____		
Aspirin or Tylenol	Yes	No
Codeine, Morphine, Demerol	Yes	No
Any other pain medication	Yes	No
Any other immunizations	Yes	No
Iodine	Yes	No
Betadine	Yes	No
Antihistamines	Yes	No
Any other drug _____	Yes	No
Any Food	Yes	No
Adhesive Tape	Yes	No
Latex	Yes	No
Contrast Dye	Yes	No

PLEASE LIST ANY ALLERGIES NOT LISTED:

HABITS:

Do you sleep well?	Yes	No
Do you regularly use alcoholic beverages?	Yes	No
Every day?	Yes	No
Exercise?	Yes	No
Do you have a decreased appetite?	Yes	No
Any known risk for HIV infection?	Yes	No
Any known exposure to Asbestos?	Yes	No

WOMEN ONLY:

Age at onset of menstruation _____
 Date of last period _____
 Is it possible you may be pregnant? _____
 Menstrual cycle _____ days from start to finish _____
 Cycle: _____ regular _____ irregular
 Usual duration of flow _____ days
 Flow: _____ Heavy _____ Medium _____ Light
 Pregnancies: How Many? _____
 Children Born Alive? _____
 Miscarriages? _____
 Stillbirth? _____
 Prematures? _____
 Cesarean sections? _____
 Complications? _____

SMOKING CESSATION

Have you ever smoked?	Yes	No
How long since you stopped?	_____	
How many years?	_____	
How many packs/day?	_____	
Check those you use:		
Cigarettes	_____	
Cigars	_____	
Pipe	_____	
Chewing Tobacco	_____	
Snuff	_____	

PHYSICIAN ONLY

Tobacco screening performed and cessation encouraged with literature provided and prescription offered.

MEDICATIONS

**PLEASE BRING ALL MEDICATIONS
 TO YOUR FIRST APPOINTMENT INCLUDING
 VITAMINS AND/OR HERBALS.**

SEE MEDICATION RECONCILIATION FORM TO LIST

PATIENT'S SIGNATURE: _____

DATE: _____