Patient Health History

Virginia Oncology Associates

Name: ______________________ Date of Birth: ______________________ Age: ________

SS #: ______________________ Today's Date: ____________ Sex: Male ☐ Height: ________

Female ☐

Primary Care Physician: ______________________ Phone Number: ______________________

Referring MD: ______________________ Phone Number: ______________________

Other MD's: Name/Specialty ______________________

Pharmacy Name: ______________________ Pharmacy Number: ______________________

Current problem or reason for consultation: ______________________

Do you feel you need to be linked to our social worker (counseling or financial issues)? Yes ☐ No ☐

PAST MEDICAL HISTORY: *Please check all the boxes that apply*

Allergies	☐	Hepatitis/Liver Disease	☐
Anemia/Blood Disorders	☐	Hypercholesterolemia	☐
Arthritis	☐	Hypertension	☐
Asthma	☐	Irregular Heartbeat	☐
Blood Clots	☐	Kidney Disease	☐
Cancer	☐	Pancreatitis	☐
Cataracts	☐	Sickle Cell Disease	☐
Colitis	☐	Sinusitis	☐
Diabetes	☐	Stroke	☐
Emphysema	☐	Thyroid	☐
GERD	☐	Tuberculosis	☐
Glaucoma	☐	Ulcers	☐
Heart Disease	☐		

Other: ______________________

Other: ______________________

Any unusual childhood infections or illnesses? ______________________

OPERATIONS: *Please list year, operation and surgeon (if known)*

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

ROUTINE CANCER SCREENING TESTS: *List last date (if known)*

Mammogram: ______________________

Breast Exam: ______________________

Pap Smear/Pelvic Exam: ______________________

Stool for Occult Blood: ______________________

Prostate Exam/PSA: ______________________

Chest X-Ray: ______________________

Colonoscopy/Sigmoidoscopy: ______________________

SOCIAL HISTORY:

Marital Status: ______________________

Number of Children: ______________________ Age/Sex of Children: ______________________

Spouse Name: ______________________

Spouse Occupation: ______________________

Patient Occupation: ______________________

Highest Level of Education: ______________________

Patient Lives With:

Self ☐	Child ☐
Spouse ☐	Parent(s) ☐
Sibling(s) ☐	Friend ☐
	Other ☐ ______________

City of Residence: ______________

Have you completed an advance directive? Yes ☐ No ☐

Have you completed a living will? Yes ☐ No ☐

Smoking History

Cigarettes ☐ How Many Years? ______________________

Cigars ☐ Number Per Day ______________________

Pipe ☐ If Quit, When? ______________________

Alcohol History

Beer ☐ How Many Years? ______________________

Wine ☐ How Much Per Day/Week/Month? ______________________

Liquor ☐ If Quit, When? ______________________

Recreational Drug Use ☐ Blood Transfusions ☐ HIV Testing ☐

Nutritional Supplements: ______________________

ALLERGIES TO MEDICATIONS: Yes ☐ No ☐

NAME OF DRUG(S)/TYPE OF REACTION:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

MEDICATIONS:

NAME OF DRUG	DOSE (mg or mcg)	HOW MANY TIMES DAILY	HOW LONG (MONTH/YEARS)

Vaccinations: *Please provide date of last vaccination*

Pneumonia: ________________________ Flu: ____________________ Shingles: __________________________

FAMILY HISTORY:

Relative	Age, If Living	Health Problems	If Deceased, Cause
Father			
Mother			
Sis/Bro			
Sis/Bro			
Sis/Bro			
Sis/Bro			
Sis/Bro			

For other relatives such as grandparents, aunts and uncles: *Please check all boxes that apply*

Anemia	☐	Diabetes	☐
Blood Clots	☐	Heart Disease	☐
Blood Disorders	☐	Hypertension	☐
Cancer	☐	Stroke	☐

Approximatley 10% of cancer is hereditary. If you are concerned your family may be at risk, genetic counseling may be appropriate for you.

Would you like to discuss this with your physician? Yes ☐ No ☐

REVIEW OF SYSTEMS: *Please check all boxes that apply*

GENERAL	FEVER	☐	WEIGHT LOSS	☐	FATIGUE	☐
	CHILLS	☐	WEIGHT GAIN	☐	NIGHT SWEATS	☐
HEAD	HEADACHES	☐	RINGING IN EARS	☐	TOOTHACHE	☐
	BLACKOUTS	☐	SINUSITIS	☐	DOUBLE VISION	☐
	SEIZURES	☐	POST NASAL DRIP	☐	BLURRED VISION	☐
	DIZZINESS	☐	SORE THROAT	☐	CATARACTS	☐
	HEARING LOSS	☐	HOARSENESS	☐	GLAUCOMA	☐
	EARACHE	☐	SORE TONGUE	☐	LAST EYE EXAM ______________	
	BLEEDING GUMS	☐	NOSEBLEEDS	☐		
CHEST	COUGH	☐	SHORTNESS OF BREATH	☐	HEART MURMUR	☐
	SPUTUM	☐	CHEST PAIN	☐	RHEUMATIC FEVER	☐
	COUGHING UP BLOOD	☐	PALPITATIONS	☐	HIGH BLOOD PRESSURE	☐
	WHEEZING	☐	SWELLING OF FEET	☐	LAST CHEST X-RAY ____________	
	BRONCHITIS	☐	ASTHMA	☐		
NECK	LUMPS	☐	GOITER	☐	PAIN OR STIFFNESS	☐
BREAST	LUMPS	☐	PAIN	☐	NIPPLE DISCHARGE	☐
ABDOMEN	NAUSEA	☐	ABDOMINAL PAIN	☐	CONSTIPATION	☐
	VOMITING	☐	HIATAL HERNIA	☐	DIARRHEA	☐
	PAIN WHEN SWALLOWING	☐	ULCER	☐	HEMORRHOIDS	☐
	DIFFICULTY SWALLOWING	☐	GAS	☐	BLOOD IN STOOLS	☐
	INDIGESTION	☐	BLOATING	☐	BLACK STOOLS	☐

CONTINUE REVIEW OF SYSTEMS: *Please check all boxes that apply*

URINARY/GYN	BLOOD IN URINE ☐	# OF PREGNANCIES _________	
	BURNING WITH URINATION ☐	# OF MISCARRIAGES ________	SPOTTING ☐
	FREQUENT URINATION ☐	# OF ABORTIONS ___________	CRAMPING ☐
	DIFFICULTY STARTING TO URINATE ☐	# OF CHILDREN _____________	DISCHARGE ☐
	BLADDER/ KIDNEY INFECTIONS ☐	LAST MENSTRUAL PERIOD ____________________	VAGINAL INFECTIONS ☐
	GETTING UP AT NIGHT TO URINATE ☐	DURATION ____________________	LAST PAP SMEAR _____________
	SENSE OF FULL BLADDER ☐	INTERVAL ____________________	
SKIN	RASH ☐	ITCHING ☐	CHANGE IN HAIR OR NAILS ☐
NEURO-MUSCULAR	JOINT STIFFNESS ☐	SWELLING ☐	NIGHT CRAMPS ☐
	JOINT PAIN ☐	BACK PAIN ☐	VARICOSE VEINS ☐
HEMATOLOGICAL	EASY BRUISING OR BLEEDING ☐	ANEMIA ☐	PAST INFUSION ☐
			TRANSFUSION REACTIONS ☐
ENDOCRINE	THYROID PROBLEMS ☐	HOT OR COLD INTOLERANCE ☐	EXCESSIVE THIRST OR HUNGER ☐
PSYCHIATRIC	ANXIETY ☐	DEPRESSION ☐	MEMORY LOSS ☐
	NERVOUSNESS ☐		

PATIENT'S SIGNATURE: ____

PHYSICIAN'S SIGNATURE: ____

Personal and Family History of Cancer

Please read this information carefully before completing the attached family history questionnaire.

We are interested in learning as much as possible about any history of cancer in your family. Information that is necessary when assessing a family history of cancer includes:

WHO? Which relatives have had cancer and how are they related to you?
WHAT? What type(s) of cancer did the relative have?
AGE? How old was the relative when they were diagnosed?

Instructions:

1) **Please fill in the family history form as completely as you can, including relatives who have had cancer AND those who have not.**
2) **Our assessment of your family history is most accurate if you can provide us with as much detailed information as possible. We encourage you to talk with your family members and to obtain medical records confirming cancer diagnoses whenever possible.**

Have you ever had cancer? Yes _____ No _____ If yes, what type? ____

Age and year of diagnosis ____________________________

What type of treatment did you have?____

____

At what hospital were you diagnosed and treated? ____

Your immediate family (If additional space is needed, please copy this page.)

Name of Individual	Male or Female	Date of birth or age	Date of death or age	Cause of Death	Affected with cancer? If yes, what type of cancer?	Age/date of cancer diagnosis	Does this person have children?
Your children 1.							#Sons ____ #Daughters ____
2.							#Sons ____ #Daughters ____
3.							#Sons ____ #Daughters ____
4.							#Sons ____ #Daughters ____
5.							#Sons ____ #Daughters ____
6.							#Sons ____ #Daughters ____

Your immediate family (If additional space is needed, please copy this page.)
Please mark individuals with an * if a half-sister or half-brother.

Name of Individual	Male or Female	Date of birth or age	Date of death or age	Cause of Death	Affected with cancer? If yes, what type of cancer?	Age/date of cancer diagnosis	Does this person have children?	Have any of their children had cancer? If yes, use space below grid.
Your mother								
Your father								
Your brothers and sisters 1.							#Sons ____ #Daughters ____	
2.							#Sons ____ #Daughters ____	
3.							#Sons ____ #Daughters ____	
4.							#Sons ____ #Daughters ____	
5.							#Sons ____ #Daughters ____	
6.							#Sons ____ #Daughters ____	

Complete the space below only if any children of individuals listed on this page have had cancer (your nieces and nephews).

*	Name of Niece or Nephew	Name of Parent	Current Age or Age of Death	Type of Cancer	Age at diagnosis

Your mother's family (If additional space is needed, please copy this page.)

Please mark individuals with an * if a half-sister or half-brother of your mother.

Name of Individual	Male or Female	Date of birth or age	Date of death or age	Cause of Death	Affected with cancer? If yes, what type of cancer?	Age/date of cancer diagnosis	Does this person have children?	Have any of their children had cancer? If yes, use space below grid.
Your grandmother								
Your grandfather								
Your mother's siblings 1.							#Sons ____ #Daughters ____	
2.							#Sons ____ #Daughters ____	
3.							#Sons ____ #Daughters ____	
4.							#Sons ____ #Daughters ____	
5.							#Sons ____ #Daughters ____	
6.							#Sons ____ #Daughters ____	

Complete the space below only if any children of individuals listed on this page have had cancer (your first cousins).

*	Name of Cousin	Name of Parent	Current Age or Age of Death	Type of Cancer	Age at diagnosis

Your father's family (If additional space is needed, please copy this page.)

Please mark individuals with an * if a half-sister or half-brother of your father..

Name of Individual	Male or Female	Date of birth or age	Date of death or age	Cause of Death	Affected with cancer? If yes, what type of cancer?	Age/date of cancer diagnosis	Does this person have children?	Have any of their children had cancer? If yes, use space below grid.
Your grandmother								
Your grandfather								
Your father's siblings 1.							#Sons ____ #Daughters ____	
2.							#Sons ____ #Daughters ____	
3.							#Sons ____ #Daughters ____	
4.							#Sons ____ #Daughters ____	
5.							#Sons ____ #Daughters ____	
6.							#Sons ____ #Daughters ____	

Complete the space below only if any children of individuals listed on this page have had cancer (your first cousins).

*	Name of Cousin	Name of Parent	Current Age or Age of Death	Type of Cancer	Age at diagnosis

Other family members who have had cancer (If additional space is needed, please copy this page.)

List name and relationship to you.	Male or Female	Date of birth or age	Date of death or age	Cause of Death	Affected with cancer? If yes, what type of cancer?	Age/date of cancer diagnosis
1.						
2.						
3.						
4.						
5.						
6.						