

Patient Health History



Name: _____ Date of Birth: _____ Age: _____
 SS #: _____ Today's Date: _____ Sex: Male Female Height: _____
 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 | <input type="checkbox"/> | Hepatitis/Liver Disease | <input type="checkbox"/> |
| Anemia/Blood Disorders | <input type="checkbox"/> | Hypercholesterolemia | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Irregular Heartbeat | <input type="checkbox"/> |
| Blood Clots | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Pancreatitis | <input type="checkbox"/> |
| Cataracts | <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> |
| Colitis | <input type="checkbox"/> | Sinusitis | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | Thyroid | <input type="checkbox"/> |
| GERD | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | | |

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

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

- | | | | |
|-----------------|--------------------------|---------------|--------------------------|
| Anemia | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> |
| Blood Clots | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> |
| Blood Disorders | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |

Approximately 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

- Do you have a Living Will? Yes
 No

- Do you have a Healthcare Power of Attorney? Yes
 No

- Would you like further information on either of the above questions? Yes
 No

REVIEW OF SYSTEMS: Please check all boxes that apply

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

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

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

PATIENT'S SIGNATURE: _____

PHYSICIAN'S SIGNATURE: _____

Personal and Family History of Cancer

Name Patient: _____

DOB: _____

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							#Sons _____ #Daughters _____
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							#Sons ____ #Daughters ____	
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							#Sons ____ #Daughters ____	
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.						