For Office Use Only Date ___________
Vital Signs: B/P__________ Resp. __________ O2 Sat __________ % HR __________ Weight__________ Height __________

PERSONAL INFORMATION

Name: ____ Date of Birth_____/____/____ Age: ___
Home Ph: (___)______-_________ Work Ph: (___)____-__________ Cell Ph: (___)_______ - _________
Emergency Contact: ______________________ Relationship:_____________ Phone: (___)___ - ________

PHYSICIAN INFORMATION

Referring Physician: ____________________ City/State: __________ Phone: (___) ____ - _________
Medical Oncologist: ____________________ City/State: __________ Phone: (___) ____ - _________
Surgeon: ____________________ City/State: __________ Phone: (___) ____ - _________
Primary Care Physician: ____________________ City/State: __________ Phone: (___) ____ - _________
Other: ____________________ City/State: __________ Phone: (___) ____ - _________

HISTORY OF PRESENT ILLNESS

What were your initial symptoms? ____
When did they begin? ____
Who did you initially see to address the problem? ____

Which of the following test have been done to investigate the problem?

TEST	DATE	TEST	DATE
CT SCAN		**PET SCAN**	
MRI		**BONE SCAN**	
MAMMOGRAM		**COLONOSCOPY**	
BIOPSY		**BRONCHOSCOPY**	
SURGERY		**OTHER (please list)**	

Have you ever had chemotherapy? Yes No
If so, list the type of chemotherapy give: ____
What were the dates of treatment? ____

Have you ever had radiation therapy? Yes No
If so, what area was treated? ____
What were the dates of treatment?____

CURRENT MEDICATIONS: Please bring list of medications, if you need additional space

Medications	Dose	Frequency	Prescribed By

HERBS/SUPPLEMENTS

ALLERGIES

None Contrast Dye Surgical Tape Seasonal Allergies Shellfish
Other: (please list) ____

Medication Allergy	Type of Reaction

____
MD Initials

MEDICAL HISTORY **(please check any of these you have been diagnosed with and indicate the year diagnosed)**

√		*Year*		√		*Year*
	Cataracts				History of Colon Polyps	
	Glaucoma				Kidney Failure	
	Difficulty Hearing				Kidney Stones	
	Thyroid Disease or Goiter				Cystitis or Bladder Infections	
	Chronic Bronchitis/Emphysema/COPD				Urinary Tract Infections	
	Asthma				Arthritis	
	Tuberculosis				Multiple Sclerosis	
	Irregular Heart Beat				Parkinson's disease	
	Heart Murmur				Other Neurologic Problems	
	High Blood Pressure				Lupus	
	High Cholesterol				Scleroderma	
	Congestive Heart Failure				Skin Condition	
	Heart Attack				Other Collagen Disease	
	Angina				Blood Clots or Clotting Disorder	
	Stroke or paralysis				Anemia	
	Pacemaker/Defibulator				Seizures or Epilepsy	
	Hernia				Depression	
	Ulcerative Colitis				Severe Anxiety	
	Ulcers of Stomach or Duodenum				Psychiatric Treatment	
	Crohns Disease				Diabetes or Sugar	
	Irritable Bowel Syndrome				History of falls	
	Diverticular disease				HIV/AIDS	
	Hepatitis or Liver Disease				Other:	
	Pancreatitis				Other:	

PAST SURGICAL HISTORY

Type of Surgery	Date of Surgery	Surgeon	Hospital	Complications

FAMILY HISTORY

Relation to You		Diseases	Cause of Death
Mother	Alive Deceased		
Father	Alive Deceased		
Sister	Alive Deceased		
Brother	Alive Deceased		
Maternal Grandmother	Alive Deceased		
Paternal Grandmother	Alive Deceased		
Maternal Grandfather	Alive Deceased		
Paternal Grandfather	Alive Deceased		
Aunt/Uncle	Alive Deceased		
Other:	Alive Deceased		

Other medical problems that run in the family:

MD Initials

GYNECOLOGIC HISTORY (female only)

Age at first menstrual cycle: __________ Last menstrual period: __________ Age at menopause: _______
Age at first pregnancy: __________ # of pregnancies: __________ # of live births: ____________
Did you breast feed? Yes No Did you/do you use birth control? Yes No
Duration of birth control pill use: __________ Duration of hormone replacement therapy: _____________
Bra Size: __________ Age at first mammogram: __________Date of last mammogram______________
GYN Problems/Infections: ____
Date of last PAP Smear? ___________________ Where was it performed? _________________________
Are you sexually active? Yes No If yes, age when you became sexually active: ____________

PROSTATE HISTORY (male only)

Age at first PSA: __________ Is your PSA checked regularly? Yes No
Are you sexually active? Yes No
If yes, do have impotence or difficulty with erection? Yes No
Have you had a TURP (Roto-rooter)? Yes No
If yes, what was the date of the surgery? ____
How many times do you urinate during the night? ____________________
Have you had prostate infections? Yes No
If yes, what are the dates of the infection? ____

SOCIAL HISTORY

Personal Situation: Married Single Widowed Divorced Separated
Children's ages: Boys____________________________ Girls ______________________________

Living Situation: Home Apartment Mobile Home Nursing Home Assisted Living
Name/address: ________________________
How many people live with you?________________ Any pets? Yes No, Type: ____________

Highest Education: High School Trade School College Graduate School

Current Work Situation: Full-time Part-time Medical leave Retired
Occupation: ____

Tobacco use: None Cigarettes Cigars Snuff/Chew Pipe
How old were you when you started smoking? _________ How many years have you smoked?_________
Are you still smoking? Yes No If no, when did you quit? _____________________________
If yes, how many packs per day do you smoke? ___________ Are you interested in quitting Yes No

Alcohol Use: None Beer Wine Liquor
How old were your when you started drinking? ______ Do you have a history of alcohol abuse Yes No
Are you still using alcohol? Yes No If no, when did you quit? ___________________________
If yes, how many drinks do you have per week? ____________ Are you interested in quitting? Yes No

Drug Use: None Marijuana Cocaine Heroin Amphetamines
How old were you when you started using drugs? _______Do you have a history of drug abuse? Yes No
Are you still using drugs? Yes No If no, when did you quit?____________________________
If yes, how often do you use drugs? _______________________ Are you interested in quitting? Yes No

Exercise/Activities: ____
Frequency of exercise/activities: _____________________________________

Please describe any emotional/spiritual/cultural practices that may influence your medical care:

____

Would you like to discuss advanced care planning? Yes No

Do you have a living will? Yes No

MD Initials

REVIEW OF SYSTEMS (circle all that apply)

EYES	**GASTROINTESTINAL**	**NEUROLOGIC**
Corrective lenses, Vision loss, Cataracts, Black spots, Blurred vision, Other, Double vision, Tunnel vision	Nausea, Constipation, Vomiting, Abdominal pain, Black Stool, Bloody stool, Hemorrhoids, Gas, Jaundice, Other, Diarrhea	Headaches, Tingling, Weakness, Tremors, Numbness, Imbalance/falls, Dizziness, Difficulty walking, Seizures, Other, Decreased coordination
EARS/NOSE	**URINARY**	**LYMPHATIC/HEMATOLOGIC**
Hearing loss, Decreased smell, Earache, Sinus trouble, Vertigo, Nose bleeds, Ear pain/ringing, Other	Pain, Night-time urination, Burning, Weak stream, Frequency, Blood in urine, Incontinence, Other	Swollen glands, Decreased blood counts, Easy bruising, Other
CARDIOVASCULAR	**MUSCULOSKELETAL**	**SKIN/HAIR**
Chest pain/pressure, Murmur, Leg/arm swelling, Irregular heart beat, Palpitations, Other, Difficulty lying flat	Back/neck pain, Stiffness, Bone pain, Other, Joint pain, Decreased range of motion	Hair Loss, Rash, Itching, Other, Ulcers, Change in skin color
LUNG	**THROAT**	**MOUTH**
Dry cough, Other, Productive cough, Coughing up blood, Shortness of breath, Pain with inspiration	Hoarseness, Change in voice, Difficulty swallowing, Painful swallowing, Other	Mouth pain, Dental problems, TMJ, Oral ulcers, Other
BREAST	**GYNECOLOGIC**	**GENERAL**
Swelling, Lumpy breast, Pain, Breast mass, Nipple discharge, Other, Skin changes	Vaginal discharge, Pelvic pain, Bleeding, Other, Itching, Painful intercourse	Fever, Weight gain, Chills, Weight loss, Fatigue, Night sweats, Loss of appetite, Other
PSYCHIATRIC	**PAIN**	
Depression, Irritability, Anxiety, Other, Claustrophobia, Trouble Sleeping	Are you experiencing pain? Yes No Please rate your pain 0 – 10 (0 = no pain, 10 = worst pain): ______________ What makes the pain better: ____ What makes the pain worse: ____	

_______________________________ Patient Signature

_______________________________ Nurse Signature

_______________________________ M.D. Signature