Highlands Oncology
Patient History

Name (First and Last) ______________________________ Today's Date: ______________

Date of Birth: ______________ Referring Physician: ______________________________

❑ Male ❑ Female Primary Care Physician: ______________________________

OB/Gyn Physician: ______________________________

Other Physicians: ______________________________

Reason for Today's Visit: ______________________________

____

Personal Medical History: Please check all that apply and include year of diagnosis

		Year	
❑	Alcohol dependence		
❑	Anemia		
❑	Angina/chest pain		
❑	Anxiety		
❑	Asthma		
❑	Blood disorder Type________		
❑	Cancer Type_________		
❑	Cirrhosis, due to alcohol		
❑	Colostomy/ileostomy		
❑	Coronary artery disease		
❑	Congestive heart disease/CHF		
❑	Chronic obstructive pulmonary disease/COPD		
❑	Depression		
❑	Diabetes Type__________		
❑	Dialysis		
❑	Drug dependence, Drug name_______________		
❑	Emphysema		
❑	GERD		
❑	Heart arrhythmia		
❑	Heart attack/MI		

		Year	
❑	Heart valve disease		
❑	Hepatitis,Type__________		
❑	High blood pressure		
❑	High cholesterol		
❑	HIV/AIDS		
❑	Inflammatory bowel disease		
❑	Kidney disease/renal failure, Stage________		
❑	Neuropathy		
❑	Organ transplant, Type _________		
❑	Parkinson's disease		
❑	Paralysis		
❑	Pneumonia		
❑	Rheumatoid arthritis		
❑	Schizophrenia		
❑	Seizure disorder		
❑	Stroke		
❑	Thyroid disease		
❑	Tuberculosis		
❑	Ulcer Type__________		
❑	Vertebral fractures		
❑	Other_______________		

Hospitalizations/Surgeries: Please list all hospitalizations and surgeries

	Date	Reason for Hospitalization or Type of Surgery	Where	Doctor
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Previous Treatment for Cancer (if applicable) When, Where

Radiation Therapy: ______________________________

Chemotherapy: ______________________________

Hormone Therapy: ______________________________

patienthistoryform updated 5/2017

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Immunizations: Please check previous immunizations received and include date of last vaccine if known.

Flu ☐	Hepatitis B ☐
Shingles ☐	Pneumonia ☐

Medications: Please list current prescriptions and over-the-counter medications, as well as herbals, supplements and vitamins.

	Medication	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

Pharmacy Name and location ______________________________

Allergies

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list the medications that you are allergic to and the type of reaction:

____

____

____

____

Are you allergic to:

Contrast/IV dye for scans ☐Yes ☐ No

Latex: ☐Yes ☐ No

Tape: ☐Yes ☐ No

Vaccines: ☐Yes ☐ No If yes, please list the type of vaccine: ____________

Other allergies: ☐Yes ☐ No

If yes, please list other allergies: ______________________________

Blood Transfusions

Have you ever had a blood transfusion? ☐ Yes ☐ No Reason: ____________

If yes, did you have a reaction? ☐ Yes ☐ No

Date of last blood transfusion: ____________

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Screenings

	Date	
Last mammogram (female)		
Last PAP smear (female)		
Last colonoscopy or sigmoidoscopy		
Last bone density scan		
Other		

Social History

Living arrangement: ❑ Single ❑ Married ❑ Partnered ❑ With family ❑ Separated ❑ Divorced ❑ Widowed ❑ Care Facility

Number of pregnancies ______________ Number of children:______________

Occupation (previous if retired): ______________________________ ❑ Retired

Have you served in the military? ❑ Yes ❑ No If yes, dates of service ________________

Do you currently use tobacco products:

❑ Yes Number per day: ❑ Cigarettes: _______ ❑ Cigars:_________ ❑ Pipe:_________ ❑ Chewing tobacco:_________

For how many years have you used the above tobacco product? _________________________

❑ No Have you ever used tobacco products in the past? ❑ Yes ❑ No

When did you quit? ___________ For how many years did you use tobacco products? ______________

How many servings of wine, beer or other alcoholic beverage(s) do you drink per day? _________Per week?__________

Do you have a history of alcoholism? ❑ Yes ❑ No

Have you used illegal drugs? ❑ Yes ❑ No

If yes, which ones? ______________________________

Do you use marijuana? ❑ Yes ❑ No

What do you do for exercise?_________________________How many times per week? _______________________

Do you have an Advance Directive, Living Will, or Power of Attorney? ❑ Yes ❑ No

If you have one of these, please bring to your next appointment

Family history of cancer

	Type of Cancer	Age at Diagnosis	Alive or Deceased
Father			
Mother			
Brother			
Sister			
Son			
Daughter			
Grandfather			
Grandmother			
Uncle			
Aunt			

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Symptoms: Please check all that apply or *None*

Do you have pain? ❏ Yes ❏ No
if yes, where? ______________ Intensity (1-10) ______________ Freqency: ______________

Constitutional:
- ❏ Appetite
  - ❏ Good
  - ❏ Fair
  - ❏ Poor
- ❏ Weight loss
- ❏ Fatigue
- ❏ Generalized weakness
- ❏ Fever
- ❏ Altered taste
- ❏ Chills
- ❏ Night sweats
- ❏ Hot flashes
- ❏ None

Eyes:
- ❏ Glasses/contacts
- ❏ Blurred vision
- ❏ Double vision
- ❏ Dry eyes
- ❏ None

Ears, nose, mouth, throat:
- ❏ Hearing loss
- ❏ Ringing in ears
- ❏ Nose bleeds
- ❏ Sinus tenderness
- ❏ Hoarseness
- ❏ Sore throat
- ❏ Bleeding gums
- ❏ Mouth sores
- ❏ Dry mouth
- ❏ None

Cardiovalscular/Heart:
- ❏ Chest pain
- ❏ Irregular heartbeat
- ❏ Swollen feet, ankle or hands
- ❏ None

Resipratoty/Lungs:
- ❏ Cough
- ❏ Sputum or phlegm production
- ❏ Coughing up blood
- ❏ Shortness of breath
- ❏ Wheezing
- ❏ None

Gastrointestinal:
- ❏ Nausea
- ❏ Vomiting
- ❏ Difficulty swallowing
- ❏ Frequent heartburn
- ❏ Abdominal pain
- ❏ Diarrhea
- ❏ Constipation
- ❏ Black stools
- ❏ Change in bowel habits
- ❏ Hemorrhoids
- ❏ None

Genitourinary:
- ❏ Pain/burning with urination
- ❏ Excessive nighttime urination
- ❏ Slow starting or stopping
- ❏ Urgency
- ❏ Unable to hold urine
- ❏ Blood in the urine
- ❏ None

Gynecologic
- ❏ Vaginal dryness
- ❏ Vaginal bleeding
- ❏ Vaginal discharge
- ❏ Pelvic pain
- ❏ None

Musculoskeletal:
- ❏ Bone pain
- ❏ Muscle pain
- ❏ Joint pain
- ❏ Swollen joints
- ❏ Back pain
- ❏ Limited range of motion
- ❏ None

Endocrine:
- ❏ Heat intolerance
- ❏ Cold intolerance
- ❏ Excessive sweating
- ❏ Increased thirst
- ❏ None

Neurological:
- ❏ Headaches
- ❏ Seizures
- ❏ Poor coordination
- ❏ Weakness of arms or legs
- ❏ Paralysis
- ❏ Termor
- ❏ Numbness in arms or legs
- ❏ Dizziness
- ❏ None

Immunologic/Infections:
- ❏ Severe allergic reactions
- ❏ Frequent or severe infections
- ❏ Pollen allergies/hay fever
- ❏ None

Integumentary/Skin:
- ❏ Rash
- ❏ Itching
- ❏ A sore that won't heal
- ❏ Dry skin
- ❏ None

Hematologic/Lymphatic:
- ❏ Easy bruising
- ❏ Abnormal bleeding
- ❏ Enlarged lymph nodes
- ❏ None

Psychiatric:
- ❏ Anxiety
- ❏ Depression
- ❏ Trouble sleeping/insomnia
- ❏ Memory loss
- ❏ Confusion
- ❏ None

Breasts
- ❏ Breast mass
- ❏ Breast tenderness
- ❏ Nipple discharge
- ❏ Breast skin changes
- ❏ None