PATIENT INFORMATION

Patient Name ______________________ **Date of Birth** __________ **Sex** ______

Address ____

City, State, Zip ______________________________ **SS#** ______________

Home PH # (   )______________ **Cell PH #** (   )______________ **Work PH #** (   )______________

Email Address ____

It is our practice that you access all labs, diagnosis information, medication history, and current medication list through our online Patient Portal.

Marital Status: SINGLE MARRIED LIFE PARTNER DIVORCED WIDOWED

Religion ______________________________ **Practicing/Active?** YES NO

Would you accept a blood transfusion if you needed one? YES NO

Race (please circle): Caucasian/White African American/Black Am. Indian / Native Alaskan Asian
Native Hawaiian / Pacific Islander Other ______________________

Ethnicity—Are you Hispanic/Latino? YES NO **Diabetic?** YES NO

Smoker? YES NO **Living Will?** YES NO **Durable Medical Power of Attorney?** YES NO

Patient Employer ______________________________ **Work PH #** (   )______________

Spouse Name ______________________ **Date of Birth** __________ **SS#** ______________

Spouse's Employer ______________________________ **Work PH #** (   )______________

Primary MD ______________ **Location** ______________ **PH #** (   )______________

EMERGENCY CONTACTS ***(Please list two)***

Name ______________________________ **Relationship** ______________

Address______________________________ **Home PH #** (   )______________

City, State, Zip ______________________________ **Work/Cell PH #** (   )______________

May we release information to this Emergency Contact? YES NO

Name ______________________________ **Relationship** ______________

Address______________________________ **Home PH #** (   )______________

City, State, Zip ______________________________ **Work/Cell PH #** (   )______________

May we release information to this Emergency Contact? YES NO

Name: ______________________________

Date of Birth: ______________________________

Today's Date: ______________________________

Reason for Today's Visit: ______________________________

____

____

Travel Time to This Clinic: ______________________________

PREVIOUS CANCER DIAGNOSES

Types of Cancer: ______________________________

____

Treatment Received and Where: ______________________________

____

____

PERSONAL MEDICAL HISTORY

Allergies: ______________________________

____

Illnesses / Medical History: ______________________________

____

____

Past Surgeries ______________________________

____

____

____

SOCIAL HISTORY

Currently Live With: ______________________________

Alcohol (Quantity per Week): ______________________________

Tobacco Use (circle): CURRENT NEVER PAST

CIGARETTES CIGARS CHEWING TOBACCO

Amount smoked per day ______________________________

Year started ______________ Year quit ______________

Illegal Drug Use (circle): YES NO

WORK HISTORY

Occupation(s): ______________________________

____

Military Service (past or present): ______________________________

____

Any exposure to toxins, fumes, radiation, or chemicals?

(circle): YES NO If yes, what types? ______________

____

FAMILY MEDICAL HISTORY

Please include parents, grandparents, siblings, aunts, and uncles.

Relative	Illness	Age at Diagnosis	Alive/Deceased

NAME: ____ **DATE OF BIRTH:** ____________________

REVIEW OF SYSTEMS

CONSTITUTIONAL	YES	NO
Weight loss in past year	___	___
Fever in last month	___	___
Night sweats	___	___
Fatigue	___	___
Appetite change	___	___

EYES/EARS/NOSE/THROAT	YES	NO
Blurred or double vision	___	___
Nose bleeds	___	___
Hearing loss	___	___
Mouth sores	___	___
Sore throats	___	___
Hoarseness	___	___
Trouble swallowing	___	___
Sinus problems	___	___

RESPIRATORY	YES	NO
Shortness of breath	___	___
Cough	___	___
Coughing up blood	___	___
Bronchitis	___	___
Pneumonia	___	___
Emphysema or COPD	___	___
Asthma	___	___
Blood clots to lung	___	___
Flu Shot	___	___
Date last received:	__________	
Pneumonia Shot	___	___
Date received:	__________	

CARDIOVASCULAR	YES	NO
Chest pain	___	___
Palpitations	___	___
Swelling in feet or legs	___	___
High blood pressure	___	___
Heart valve disease	___	___
Heart murmurs	___	___
Coronary artery disease	___	___
High cholesterol	___	___
Previous heart attack	___	___
Congestive heart failure	___	___
Irregular heart beat	___	___
Blood clots to leg/arm	___	___

GASTROINTESTINAL	YES	NO
Nausea/ vomiting	___	___
Abdominal pain	___	___
Liver disease/hepatitis	___	___
Peptic ulcers	___	___
Diarrhea	___	___
Rectal bleeding	___	___
Constipation	___	___
Colonoscopy	___	___
Date last performed:	____________	
Sigmoidoscopy	___	___
Date last performed:	____________	

HEMATOLOGIC	YES	NO
Anemia	___	___
Low platelet counts	___	___
Enlarged lymph glands	___	___
Abnormal bleeding	___	___
Familial thalassemia	___	___
Excessive bruising	___	___

ENDOCRINE	YES	NO
Diabetes	___	___
Thyroid disease	___	___

SKIN	YES	NO
Rash	___	___
Itchiness	___	___

NEUROLOGICAL	YES	NO
Headaches	___	___
Dizziness	___	___
Fainting	___	___
Seizures	___	___
Difficulty walking	___	___
Numbness feet/hands	___	___
Stroke	___	___

PSYCHOSOCIAL	YES	NO
Depression	___	___
Anxiety	___	___
Insomnia	___	___
Mental illness	___	___
Drug abuse	___	___
Alcohol abuse	___	___

MUSCULOSKELETAL	YES	NO
Arthritis	___	___
Osteoporosis	___	___
Joint pain	___	___
New bone pain	___	___
Fractures (in past 2 yrs)	___	___

GENITOURINARY	YES	NO
Pain with urination	___	___
Blood seen in urine	___	___
Bladder infections	___	___
Kidney infections/stones	___	___
Kidney disease	___	___

****MALES ONLY****

	YES	NO
Incontinence	___	___
Slow Stream	___	___
Dribbling	___	___
Erectile Dysfunction	___	___
Prostate/Rectal Exam	___	___
Date last performed:	__________	
PSA drawn	___	___
1st result:	__________	
Most recent result:	__________	

****FEMALES ONLY****

GYNECOLOGICAL	YES	NO
Fibrocystic ovaries	___	___
Fibrocystic breasts	___	___
Date of last mammogram:	__________	
Any breast biopsies in past	___	___
Date of last pap/pelvic exam:	_________	
# of pregnancies____# of children ____		
Breast Feed	___	___
Date of first live birth:	__________	
Age menstrual periods began:	_________	
Regular menstrual cycles	___	___
Date of last menstrual period:	____	
Are you menopausal	___	___
Age when menopause began:	_____	
Taking hormonal therapy	___	___
How long_______ Type:_________		
Birth control currently or in past?	___	___
How long_______ Type:_________		

Anything else you would like your doctor to know, please describe below:

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