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	___	___

SKIN	YES	NO
Rash	___	___
Itchiness	___	___

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	___	___

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:	_____	
Currently Pregnant	___	___
Desire for fertility	___	___

# of pregnancies____# of children ____
spontaneous abortion/miscarriage___
of therapeutic abortions ___
Breast Feed ___ ___
Age at first live birth: _____
Age menstrual periods began_____
Date of last menstrual period____
Menstrual cycle length ____ days
Menopause Status: Pre Peri Post
Age when menopause began ___
Taking hormonal therapy ___ ___
How long_____ Type _____
Taking birth control past or present ___
How long_____ Type _____
Number of Living Children _____

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

_____

_____

_____