CAPITAL REGIONAL CANCER CENTER

Patient Label

DATE: _____

PAST MEDICAL HISTORY		
Have you ever had any of the following conditions?		
Y N	**Y N**	**Y N**
☐ ☐ Acid Reflux Disease	☐ ☐ Asthma	☐ ☐ Bladder Problems
☐ ☐ Cirrhosis of the liver	☐ ☐ Diverticulosis	☐ ☐ Colitis
☐ ☐ Diabetes	☐ ☐ Diverticulitis	☐ ☐ Clotting problems (blood)
☐ ☐ Emphysema or COPD	☐ ☐ Gallstones	☐ ☐ Glaucoma
☐ ☐ Heart Failure	☐ ☐ Hepatitis	☐ ☐ High blood pressure
☐ ☐ Coronary Artery Disease	☐ ☐ Lupus	☐ ☐ Mental Illness
☐ ☐ Kidney disease	☐ ☐ Pacemaker/Defibrillator	☐ ☐ Osteoarthritis
☐ ☐ Pancreatitis	☐ ☐ Rheumatic fever	☐ ☐ Rheumatoid arthritis
☐ ☐ Prostate disease	☐ ☐ Seizures	☐ ☐ Sjogren's Syndrome
☐ ☐ Scleroderma	☐ ☐ Stroke	☐ ☐ Thyroid disease
☐ ☐ Stomach ulcers	☐ ☐ Agent Orange exposure	☐ ☐ Asbestos exposure
☐ ☐ Tuberculosis	☐ ☐ High cholesterol	☐ ☐ HIV/AIDS
☐ ☐ Other cancers (please list): _____		

Have you ever had radiation treatments? ☐ Yes ☐ No If so, what body part? _____

Where and when were treatments performed? _____

Have you ever had chemotherapy? ☐ Yes ☐ No If so, where and when was chemotherapy given?

_____

PAST SURGICAL HISTORY

Please list all surgeries (with approximate dates) you have had: _____

_____

_____

FAMILY HISTORY

Have any of your immediate family members had cancer? If so, please list relationship and type of cancer:

_____

SOCIAL HISTORY

Who do you live with? _____

Do you have access to reliable transportation? _____

Occupation: ☐ Employed (or self-employed) ☐ Student ☐ Unemployed ☐ Retired ☐ Disabled

TURN PAGE OVER TO CONTINUE

What type of work have you done? _____

If disabled, what is your disability? _____

Have you ever used tobacco products? ☐ Yes ☐ No If yes, how much? _____ How long? _____

What type(s) of product(s) have you used? _____ Date quit? _____

Have you ever regularly consumed alcohol? ☐ Yes ☐ No If yes, how much? _____ How long? _____

What type(s) of alcohol have you used? _____ Date quit? _____

What is your highest level of education? _____ Grade ☐ Some College ☐ Bachelor's Degree ☐ Masters ☐ Doctorate

MEDICATIONS: Please include prescriptions, vitamins, herbal and other non-prescription medications.		
Medication	**Dose and Frequency**	**Reason for Medication**

ALLERGIES: Are you allergic to any medications? ☐ Yes ☐ No Iodine or IV contrast Allergy? ☐ Yes ☐ No

Latex Allergy? ☐ Yes ☐ No

Medications you are allergic to	**Describe the allergic reaction to this medication**

WHEN WAS YOUR LAST FLU SHOT? _____

PHYSICIAN INFORMATION – Please let us know which doctors need copies of our notes (you may not have all of these doctors). Who referred you to us? _____

Primary care physician: _____

Surgeon(s): _____

Medical oncologist (chemo doctor): _____

Other: _____

REVIEW OF SYSTEMS

Have you had any of the following conditions in the *past 6 months*?

Y	N		Y	N	
☐	☐	Fever, chills, soaking night sweats	☐	☐	Ankle swelling
☐	☐	Lack of appetite	☐	☐	Chest pain
☐	☐	Weight loss If so, how much? _____	☐	☐	Shortness of breath
☐	☐	Skin rash or itching	☐	☐	Frequent cough
☐	☐	Growth or lump on skin	☐	☐	Coughed up blood
☐	☐	Skin tumor or moles	☐	☐	Tuberculosis (or exposure to TB)
☐	☐	Frequent or severe headaches	☐	☐	Frequent indigestion or heartburn
☐	☐	Dizziness	☐	☐	Nausea and/or vomiting
☐	☐	Fainting	☐	☐	Diarrhea
☐	☐	Seizures	☐	☐	Constipation
☐	☐	Loss of balance or coordination	☐	☐	Rectal bleeding (blood in stool)
☐	☐	Hearing loss	☐	☐	Black, tarry stools
☐	☐	Vision changes ☐ Glasses ☐ Contacts	☐	☐	Hemorrhoids
☐	☐	Difficulty swallowing	☐	☐	Jaundice/yellow skin
☐	☐	Hoarseness or change in voice	☐	☐	Frequent abdominal pain
☐	☐	Swollen lymph nodes/glands	☐	☐	Foul-smelling urine
		If so, where? _____	☐	☐	Blood in urine
☐	☐	Mass or lump in breast	☐	☐	Depression or mood changes
☐	☐	Nipple discharge or inversion	☐	☐	Anxiety
☐	☐	Bone pain	☐	☐	Post traumatic stress disorder (PTSD)

MEN ONLY

☐	☐	Decreased force of urine stream	☐	☐	Burning during urination
☐	☐	Increased frequency of urination	☐	☐	Feel like your bladder does not empty completely
		How many times do you urinate at night? _____	☐	☐	Incontinence (leaking urine)
☐	☐	Erectile dysfunction (difficulty with sex)			

WOMEN ONLY

Age at first menstruation: _____ Date of last period: _____ Age at menopause: _____

# of pregnancies: _____ # of live births: _____ Age at 1st pregnancy: _____

When was your last mammogram? _____ When was your last Pap test? _____

Y	N		Y	N	
☐	☐	Did you breastfeed? How long? _____	☐	☐	Did you take birth control? When? _____
☐	☐	Have you taken hormone replacement therapy? Dates? _____			
☐	☐	Do you have abnormal vaginal discharge or bleeding?			
☐	☐	Do you have pain with intercourse?			

ADVANCE DIRECTIVES

Do you have a living will or an advance directive? ☐ Yes ☐ No If so, please provide us a copy so we can place it on your chart.

PATIENT/REPRESENTATIVE SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ **DATE:** _____