|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Charleston Hematology Oncology Associates, PAMedical History Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Family History | | | | | | |
| (Please write in names) | | | **If Living:** | | **If Deceased:** | | |
| Age | Health | Age at Death | Cause of Death | |
| Father | | |  |  |  |  | |
| Mother | | |  |  |  |  | |
| Brothers/Sisters | (Circle Sex) | |  |  |  |  | |
|  | M | F |  |  |  |  | |
|  | M | F |  |  |  |  | |
|  | M | F |  |  |  |  | |
|  | M | F |  |  |  |  | |
|  | M | F |  |  |  |  | |
| Sons/Daughters | (Circle Sex) | |  |  |  |  | |
|  | M | F |  |  |  |  | |
|  | M | F |  |  |  |  | |
|  | M | F |  |  |  |  | |
|  | M | F |  |  |  |  | |
|  | M | F |  |  |  |  | |
| Husband/Wife |  | |  |  |  |  | |

**Check () if any you or blood relative has had any of the following:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Condition** | **You** | | **Relative** | | |  | **Condition** | **You** | | **Relative** | | |
|  | Yes | No | Yes | No | Relation to you |  |  | Yes | No | Yes | No | Relation to you |
| Anemia |  |  |  |  |  |  | Heart Attack |  |  |  |  |  |
| Angina Pectoris |  |  |  |  |  |  | Heart Disease |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  | Heart Disease (Rheumatic) |  |  |  |  |  |
| Asthma |  |  |  |  |  |  | Hepatitis |  |  |  |  |  |
| Bleeding Tendency |  |  |  |  |  |  | High Blood Pressure |  |  |  |  |  |
| Cancer |  |  |  |  |  |  | Insanity |  |  |  |  |  |
| Colitis |  |  |  |  |  |  | Jaundice |  |  |  |  |  |
| Congenital Heart Disease |  |  |  |  |  |  | Kidney Disease |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  | Leukemia |  |  |  |  |  |
| Emphysema |  |  |  |  |  |  | Migraine |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  | Nervous Breakdown |  |  |  |  |  |
| Frequent Kidney or Bladder Infections |  |  |  |  |  |  | Stomach Ulcers |  |  |  |  |  |
| Frequent Lung Infections |  |  |  |  |  |  | Stroke |  |  |  |  |  |
| Gallbladder Disease |  |  |  |  |  |  | Suicide |  |  |  |  |  |
| Goiter |  |  |  |  |  |  | Thyroid Disease |  |  |  |  |  |
| Gout |  |  |  |  |  |  | Tuberculosis |  |  |  |  |  |
| Hay Fever |  |  |  |  |  |  | Other |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Surgeries:** | | | **Hospitalizations:** (other than operation) | |
| Year | Name of Surgery |  | Year | Reason for Hospital Stay | |
|  |  |  |  |  | |
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| **Serious Injuries :** (other than above) | | | | | |  | | **Diagnostic X-rays:** | | | | |
| Year | | Type of Injury | | | |  | | Year | | Type of X-rays | | | | |
|  | |  | | | |  | |  | |  | | | | |
|  | |  | | | |  | |  | |  | | | | |
|  | |  | | | |  | |  | |  | | | | |
| **Immunizations:** (please give date given) | | | | | | | | | | | | |
| Smallpox: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Polio: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Typhoid: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Tetanus: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Are you allergic to any medications or latex?** | **Yes** |  | **No** |  | **If yes, please complete below.** |
| Name of Medication | Reaction | | | | | |
|  |  | | | | | |
|  |  | | | | | |

**Name of your Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medications**: Check () the medications you are currently taking and write in the name of the medicine next to it. | | | | | | | | | | | | | | | | | |
|  | Antibiotics \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | |  | Iron or poor-blood medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | Aspirin, Bufferin, Anacin, Tylenol, or similar products \_\_\_\_\_\_ | | | |  | |  | Laxatives \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | Asthma or wheezing medicine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | |  | Phenobarbital or barbiturates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | Blood pressure pills \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | |  | Sleeping pills or tranquilizers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | Blood-thinners or Coumadin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | |  | Stomach or digestive medicine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | Cortisone, Prednisone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | |  | Thyroid medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | Cough Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | |  | Vitamins\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | Digitalis or heart medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | |  | Water pills, diuretics \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | Dilantin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | |  | Weight-reducing pills \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | Hormone or birth control pills \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | |  | Other Drugs (list below):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | Insulin or diabetic pills \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | |  |  | | | | | | | | |
| **Personal Habits:** | | |  |  | | | | | | |  |  | | | | | |
| Check () if you use tobacco regularly: | | |  | Cigarettes (# per day) \_\_\_\_\_\_\_\_\_\_\_ or smokeless tobacco (times per day)\_\_\_\_\_\_ | | | | |  | Pipe | | |  | Cigars (# per day) \_\_\_\_\_\_\_\_\_\_ | | | |
| If you used tobacco in the past, how long did you use when did you quit: | | | | | | | | | | | | | | | | | |
| Check (if you drink alcohol regularly: | |  | | Hard Liquor |  | 1 – 3 oz per day | | | | |  | Over 3 oz per day | | | | | |
|  | |  | | Beer |  | 1 bottle per day | | | | |  | 2 bottles | | |  | 3 or more | |
|  | |  | | Wine |  | 1 glass per day | | | | |  | 2 glasses | | |  | 3 or more | |
|  | |  | |  |  |  | | | | |  |  | | | | | |
| Do you drink coffee? | |  | | Yes |  | No | | | | |  | 3 or more cups | | | | | |
| Do you have difficulty sleeping? | |  | | Never |  | Sometimes | | | | |  | Often | | | | | |
| Do you awaken very early in the morning without apparent cause and find it difficult to fall asleep again? | | | | |  | Frequently | | | | |  | Occasionally | | |  | Rarely | |

#### PLEASE ANSWER ALL QUESTIONS

## Have you had any of the following during the past three months? Circle correct answer:

# CONSTITUTIONAL

Good general health lately…………………….. No Yes

Recent weight change…………………………. No Yes

Fever…………………………………………... No Yes

Fatigue………………………………………… No Yes

Headaches……………………………………... No Yes

# EYES

Eye disease or injury………………………….. No Yes

Wear glasses/contact lens…………………….. No Yes

Blurred or double vision……………………… No Yes

Glaucoma……………………………………... No Yes

# ENT

Hearing loss…………………………………... No Yes

Ringing in the ears……………………………. No Yes

Earaches or drainage………………………….. No Yes

Sinus problems………………………………... No Yes

Nose bleeds…………………………………… No Yes

Mouth sores…………………………………… No Yes

Bleeding gums………………………………… No Yes

Bad breath or bad taste………………………... No Yes

Sore throat or voice change……………………. No Yes

Swollen glands in neck………………………… No Yes

# CARDIOVASCULAR

Heart trouble…………………………………… No Yes

Chest pains…………………………………….. No Yes

Sudden heart beat changes…………………….. No Yes

Swelling of feet, ankles or hands……………… No Yes

# RESPIRATORY

Frequent coughing……………………………... No Yes

Spitting up blood………………………………. No Yes

Shortness of breath…………………………….. No Yes

Asthma or wheezing…………………………… No Yes

# GASTROINTESTINAL

Loss of appetite………………………………… No Yes

Change in bowel movements………………….. No Yes

Nausea or vomiting……………………………. No Yes

Frequent diarrhea………………………………. No Yes

Painful bowel movements or constipation…….. No Yes

Blood in stool………………………………….. No Yes

Stomach pain…………………………………… No Yes

# GENITOURINARY

Frequent urination……………………………… No Yes

Burning or painful urination…………………… No Yes

Blood in urine………………………………….. No Yes

Change of force of strain when urinating……… No Yes

Incontinence or dribbling………………………. No Yes

Kidney stones………………………………….. No Yes

Sexual difficulty……………………………….. No Yes

Male – testicle pain…………………………….. No Yes

Female – pain with periods…………………….. No Yes

Female – irregular periods……………………… No Yes

Female – vaginal discharge…………………….. No Yes

Female – # pregnancies \_\_\_\_\_ # miscarriages \_\_\_\_\_\_

Female – date of last pap smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Female – findings of last pap smear ❏ Normal ❏ Abnormal

# MUSCULOSKELETAL

Joint pain……………….……………………… No Yes

Joint stiffness or swelling……………………… No Yes

Weakness of muscles or joints………………… No Yes

Muscle pain or cramps………………………… No Yes

Back pain………………………………………. No Yes

Cold extremities………………………………... No Yes

Difficulty in walking…………………………… No Yes

# SKIN

Rash or itching…………………………………. No Yes

Change in skin color…………………………… No Yes

Change in hair or nails…………………………. No Yes

Varicose veins………………………………….. No Yes

Breast pain……………………………………… No Yes

Breast lump…………………………………….. No Yes

Breast discharge………………………………… No Yes

# NEUROLOGICAL

Frequent or recurring headaches………………... No Yes

Light headed or dizzy…………………………... No Yes

Convulsions or seizures………………………… No Yes

Numbness or tingling sensations……………….. No Yes

Tremors………………………………………… No Yes

Paralysis………………………………………... No Yes

Stroke…………………………………………… No Yes

Head injury……………………………………… No Yes

# PSYCHIATRIC

Memory loss or confusion……………………… No Yes

Nervousness……………………………………. No Yes

Depression……………………………………… No Yes

Sleep problems…………………………………. No Yes

# ENDOCRINE

Glandular or hormone problem………………… No Yes

Thyroid disease………………………………… No Yes

Diabetes………………………………………… No Yes

Excessive thirst or urination…………………… No Yes

Heat or cold intolerance……………………….. No Yes

Dry skin………………………………………... No Yes

Change in hat or glove size……………………. No Yes

# HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts…………………………. No Yes

Easily bruise or bleed………………………….. No Yes

Anemia…………………………………………. No Yes

Phlebitis………………………………………… No Yes

Past transfusion………………………………… No Yes

Enlarged glands………………………………… No Yes

# ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reactions to:

Penicillin or other antibiotics………… No Yes

Morphine, Demerol or other narcotics.. No Yes

Novocaine or other anesthetics………. No Yes

Aspirin or other pain remedies………. No Yes

Tetanus antitoxin or other serums…… No Yes

Iodine, methiolate or other antiseptic… No Yes

Other drugs/medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known food allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_