CHARLESTON ONCOLOGY

COMPASSIONATE CARE FOR CANCER AND BLOOD DISORDERS

# Medical History

**Name:**_____ **Age:**_____ **Date:** _____

**Referring Physician:**_____

**Other Physicians:**_____

**Chief Complaint: Please explain the reason why you are here today:**_____

_____

_____

## ✓ Check if YES

- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cataracts
- ☐ Chronic bronchitis
- ☐ Colitis
- ☐ Colonoscopy, Date_____
- ☐ Crohn's Disease
- ☐ Cystitis (Bladder Infection
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular Disease/Polyp
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Gallbladder Disease
- ☐ Glaucoma
- ☐ GYN Problems
- ☐ Heart Attack
- ☐ Heart Disease/Murmur
- ☐ Hepatic Disease
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irregular Heart Beat
- ☐ Kidney Infection
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Other Collagen Vascular Disease
- ☐ Parkinson's Disease
- ☐ Prostate Disease
- ☐ Pancreatitis
- ☐ Psychiatric Treatment
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Seizures/Epilepsy
- ☐ Severe Anxiety
- ☐ Skin Conditions
- ☐ Stroke/Paralysis
- ☐ Thyroid Disease or Goiter
- ☐ Tuberculosis
- ☐ Ulcers

**List other Medical Problems of Past Surgeries (Include approximate dates):**_____

_____

_____

_____

**Have you ever Had**:

**Any other cancer?** Yes No If yes, please explain: _____

_____

**Previous Radiation treatments?** Yes No If yes, please explain: _____

_____

**Previous Chemotherapy?** Yes No If yes, please explain: _____

_____

**Are you currently under home health or hospice care?** ☐ Home Health ☐Hospice

Name: _____

## Family History

**Has anyone in your family had cancer?** ☐Yes ☐No

If Yes, please list type and relationship: _____

_____

_____

## Social History

**Occupation:**_____

**Marital Status**: ☐Married ☐Divorced ☐Separated ☐Single ☐Widow(ed)

**Name of Spouse or Significant other:**_____

**Does principle care person live with you?** ☐ Yes ☐ No Children(#):_____

**Is this person willing to help?** ☐Yes ☐No Ages:_____

**Health of Principle Care Person:**_____

**Current Living Conditions:** ☐ Live Alone ☐ Live with family/others

Live in: ☐ House ☐Nursing/Personal care Home ☐ Assisted living

**Do you have… (If yes please explain)**

**Transportation problems?** ☐ Yes ☐ No _____

**Religious Preference (Optional)?** ☐ Yes ☐ No _____

**Any special requirements/disability?** ☐ Yes ☐ No _____

**Financial/Homecare Needs?** ☐ Yes ☐ No _____

**Living Will?** ☐ Yes ☐ No **Do you want info?** ☐ Yes ☐ No

**Smoke Cigarettes?** ☐ Yes ☐ No ☐ In the Past **Packs per day:**_____

**When did you quit?**_____ **Years Smoked:**_____

**Drink Alcohol?** ☐ Yes ☐ No **Frequency?** ☐ Occasional ☐ Moderate ☐ Heavy

## Female Gynecologic History

**Age at first menstrual period:**_____ **Age of final Menstrual period, if applicable:**_____

**Have you had irregular bleeding?** ☐ Yes ☐ No **Do you take birth control?** ☐ Yes ☐ No

**Hormone Replacement Therapy:** ☐ Yes ☐ No ☐ In the Past

**Pregnancies (#):**_____ **Live Births (#):**_____ **Miscarriages (#):**_____

**Living Children (#):**_____ **Age at first childbirth:**_____

**Breast Feeding?** ☐ Yes ☐ No **Was this your first Breast Biopsy?** ☐ Yes ☐ No

**Are you currently pregnant?** ☐ Yes ☐ No ****If yes, notify doctor or nurse****

### Medication History

Pharmacy:_____ Phone #:_____

**Please list medication currently using prescribed, over the counter, herbal, or recreational:**

| **Medication** | **Dosage** | **How Often?** | **Prescribing Doctor?** |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

*During the course of treatment, please inform the nurse of any changes to your medications*

**Have you received an influenza vaccination (flu season only)?** ☐ Yes ☐ No

### Allergies

**Allergy to X-ray dye?** ☐ Yes ☐ No **Allergy to drugs?** ☐ Yes ☐ No

**Allergy to Foods?** ☐ Yes ☐ No **Other Allergies?** ☐ Yes ☐ No

**List Allergies/ Describe Reaction:**

_____

_____

_____

_____

_____

## Pain Assessment

**Do you have Pain?** ☐ Yes ☐ No

**Please rate your pain today? 1- Being no pain and 10- extreme pain** _____

**What pain medicines or other methods do you use to relieve pain?**_____

_____

**Is there any other information that you feel is important for us to know?**_____

_____

## Review of Systems

✓ Please Check all that apply

### Constitutional

- ☐ **Fever**
- ☐ **Chills**
- ☐ **Night Sweats**
- ☐ **Loss of Appetite**
- ☐ **Fatigue**
- ☐ **Weight Gain**
- ☐ **Weight Loss**
- ☐ **Other:_____**

### Eyes

- ☐ **Change in Vision**
- ☐ **Loss of Vision**
- ☐ **Cataracts**
- ☐ **Contacts**
- ☐ **Glasses**
- ☐ **Other:_____**

### Ears

- ☐ **Change in Hearing**
- ☐ **Deafness**
- ☐ **Ringing in ears**
- ☐ **Other:_____**

### Nose

- ☐ **Nasal Stuffiness**
- ☐ **Bleeding**
- ☐ **Sinus Congestion**
- ☐ **Other:_____**

### Mouth

- ☐ **Dentures**
- ☐ **Dental Problems**
- ☐ **Ulcers/Sores**
- ☐ **Other:_____**

### Throat

- ☐ **Sore Throat**
- ☐ **Difficulty Swallowing**
- ☐ **Hoarseness**
- ☐ **Other:_____**

### Cardiovascular

- ☐ **Chest Pain**
- ☐ **Irregular Heartbeat**
- ☐ **Pacemaker**
- ☐ **Fainting Spells**
- ☐ **Swelling in Legs**
- ☐ **Cold Extremities**
- ☐ **Intermittent lower leg calf pain when walking**
- ☐ **Other:_____**

### Musculoskeletal

- ☐ **Bone Pain**
- ☐ **Joint Pain**
- ☐ **Artificial Joints**
- ☐ **Leg Pain when walking**
- ☐ **Other:_____**

### Respiratory

- ☐ **Shortness of Breath**
- ☐ **Shortness of Breath on Exertion**
- ☐ **Cough**
- ☐ **Chest Pain**
- ☐ **Coughing up Blood**
- ☐ **Require Oxygen**
- ☐ **Other:_____**

**Gastrointestinal**

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stools
- ☐ Abdominal Pain
- ☐ Difficulty Swallowing
- ☐ Pain with Swallowing
- ☐ Hemorrhoids
- ☐ Yellowing of Skin
- ☐ Change in Stools
- ☐ Other:_____

**Endocrine**

- ☐ Change in Thirst
- ☐ Frequent Urination
- ☐ Thyroid Problem
- ☐ Other:_____

**Skin**

- ☐ Rashes
- ☐ Sores
- ☐ Changes in Moles
- ☐ Lumps
- ☐ Other:_____

**Psychiatric**

- ☐ Depression
- ☐ Anxiety
- ☐ Nervousness
- ☐ Sleep Problems
- ☐ Other:_____

**Genitourinary: Male**

- ☐ Frequency of Urination
- ☐ Urgency of Urination
- ☐ Urinating Frequently at Night
- ☐ Straining with Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Sexual Dysfunction
- ☐ Leaking of Urine
- ☐ Other:_____

**Genitourinary: Female**

- ☐ Frequency of Urination
- ☐ Urgency of Urination
- ☐ Urinating Frequently at Night
- ☐ Straining with Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Sexual Dysfunction
- ☐ Leaking of Urine
- ☐ Abnormal Vaginal Bleeding
- ☐ Painful Intercourse
- ☐ Other:_____

**Breasts**

- ☐ Lump
- ☐ Nipple Discharge
- ☐ Skin Changes
- ☐ Pain
- ☐ Other:_____

**Hematologic/Lymphatic**

- ☐ Bruising
- ☐ Bleeding
- ☐ Enlarged Lymph Nodes
- ☐ Other:_____

**Neurologic**

- ☐ Headache
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Seizures
- ☐ Dizziness
- ☐ Difficulty Speaking
- ☐ Paralysis
- ☐ Unsteady Gait
- ☐ Recent Falls
- ☐ Loss of Bladder Control
- ☐ Loss of Bowel Control
- ☐ Other:_____