

**PATIENT DEMOGRAPHICS
HEALTH HISTORY FORM**

Name: _____ Today's Date: _____

Address: _____

City	State	Zip Code	Country
------	-------	----------	---------

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Date of Birth: _____

- Male
- Female

Social Security Number:

Race:

- I decline to answer
- African American/Black
- American Indian
- Asian
- Caucasian/White
- More than one race
- Other: _____

Ethnicity:

- I decline to answer
- Hispanic/Latino
- Non-Hispanic/Non-Latino

Preferred Language:

Preferred Pharmacy: _____

Preferred Pharmacy Address: _____

Preferred Pharmacy Phone Number: _____

Provider List			
	Name	Phone Number	Location
Primary Medical Oncologist			
Primary Care Physician			
Additional Physician(s)			

HEALTH HISTORY FORM

Name: _____ DOB: _____

Medical History

Diagnosis	Date

Have you ever had any of the following during blood draws: nausea, sweating, dizziness/lightheadedness, blurred/tunnel vision, feeling faint or fainting?

- Yes, what symptom(s): _____
 No

Surgery/Procedure History

Surgery/Procedure	Date Performed

Gynecological History (for females)

<p>Pregnancies:</p> <ul style="list-style-type: none"> <input type="checkbox"/> # of pregnancies _____ <input type="checkbox"/> # of full-term births _____ <input type="checkbox"/> Age at first birth _____ <input type="checkbox"/> Date of last period _____ 	<p>Date of last pap smear: _____</p> <p>Date of last mammogram: _____</p> <p>Contraceptive use, if any: _____</p>
<p>Menopause Status:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pre/Peri (still have periods, may or may not be regular) <input type="checkbox"/> Post (no period for >12 consecutive months) <ul style="list-style-type: none"> <input type="checkbox"/> Age at menopause _____ Reason: <ul style="list-style-type: none"> <input type="checkbox"/> Natural <input type="checkbox"/> Removal ovaries <input type="checkbox"/> Removal uterus <input type="checkbox"/> Total hysterectomy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown 	<p>Was your last menstrual cycle more than one year ago? Date: _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <ul style="list-style-type: none"> <input type="checkbox"/> Did you go through menopause before your cancer diagnosis? <ul style="list-style-type: none"> <input type="checkbox"/> Yes; Date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Did you have total hysterectomy? <ul style="list-style-type: none"> <input type="checkbox"/> Yes; Date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Unknown

HEALTH HISTORY FORM

Name: _____ DOB: _____

Social History		
<p>Do you have an Advance Directive?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Please list your primary caregiver (emergency contact) during treatment:</p> <p>Name: _____</p> <p>Relationship: _____</p> <p>Phone: _____</p>	
<p>Do you currently use tobacco products?</p> <p><input type="checkbox"/> Yes, use per day: _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Cigarettes: _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Cigars: _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Pipe: _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Chewing tobacco: _____</p> <p><input type="checkbox"/> No, have you used in the past:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Yes, use per day: _____</p> <p style="margin-left: 40px;"><input type="checkbox"/> Cigarettes: _____</p> <p style="margin-left: 40px;"><input type="checkbox"/> Cigars: _____</p> <p style="margin-left: 40px;"><input type="checkbox"/> Pipe: _____</p> <p style="margin-left: 40px;"><input type="checkbox"/> Chewing tobacco: _____</p> <p style="margin-left: 40px;"><input type="checkbox"/> When did you quit? _____</p> <p style="margin-left: 40px;"><input type="checkbox"/> How many years did you use tobacco products? _____</p> <p><input type="checkbox"/> No</p>	<p>How many servings of wine, beer, or other alcoholic beverage(s) do you drink per day? _____; per week? _____</p> <p>Do you have history of alcoholism?</p> <p style="margin-left: 20px;"><input type="checkbox"/> Yes</p> <p style="margin-left: 20px;"><input type="checkbox"/> No</p> <p>Do you use marijuana?</p> <p style="margin-left: 20px;"><input type="checkbox"/> Yes</p> <p style="margin-left: 20px;"><input type="checkbox"/> No</p> <p>Do you use illicit drugs?</p> <p style="margin-left: 20px;"><input type="checkbox"/> Yes; which ones? _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> No</p>	
<p>Where do you live?</p> <p><input type="checkbox"/> House/apartment</p> <p><input type="checkbox"/> Nursing home</p> <p><input type="checkbox"/> Assisted living facility</p> <p><input type="checkbox"/> Incarcerated</p> <p><input type="checkbox"/> Homeless</p>	<p>Who lives with you?</p> <p style="margin-left: 20px;"><input type="checkbox"/> Alone</p> <p style="margin-left: 20px;"><input type="checkbox"/> Spouse</p> <p style="margin-left: 20px;"><input type="checkbox"/> Significant other</p> <p style="margin-left: 20px;"><input type="checkbox"/> Children</p> <p style="margin-left: 20px;"><input type="checkbox"/> Parents</p> <p style="margin-left: 20px;"><input type="checkbox"/> Friends</p> <p style="margin-left: 20px;"><input type="checkbox"/> Other: _____</p>	<p>Have you been exposed to any of the following?</p> <p><input type="checkbox"/> Asbestos</p> <p><input type="checkbox"/> Benzene</p> <p><input type="checkbox"/> Coal</p> <p><input type="checkbox"/> Lead</p> <p><input type="checkbox"/> Mercury</p> <p><input type="checkbox"/> Radiation</p> <p><input type="checkbox"/> Red dye #3</p> <p><input type="checkbox"/> Petroleum products</p> <p><input type="checkbox"/> Xylene</p> <p><input type="checkbox"/> Other: _____</p>
<p>What is your current diet?</p> <p><input type="checkbox"/> Regular diet</p> <p><input type="checkbox"/> Dietary supplements</p> <p><input type="checkbox"/> Liquid diet</p> <p><input type="checkbox"/> Diabetic diet</p> <p><input type="checkbox"/> Vegetarian</p> <p><input type="checkbox"/> Tube feedings</p> <p><input type="checkbox"/> TPN</p>	<p>How often are you active?</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Daily activities</p> <p><input type="checkbox"/> Occasional exercise</p> <p><input type="checkbox"/> Light exercise</p> <p><input type="checkbox"/> Regular exercise</p> <p><input type="checkbox"/> Extensive exercise</p> <p>Types of exercise? _____</p>	

HEALTH HISTORY FORM

Name: _____ DOB: _____

Oncologic Family History					
Please list all first-, second-, and third-degree family members with history of cancer.					
Relationship to Patient	Maternal	Paternal	Cancer Type	Age at Diagnosis	Health Status
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased

Select all that apply regarding family history:

- Ashkenazi Jewish Ancestry
- Lynch syndrome
- Adopted – family history not known

HEALTH HISTORY FORM

Name: _____ DOB: _____

Review of Systems		
CONSTITUTIONAL <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss	HEENT <input type="checkbox"/> Hearing loss <input type="checkbox"/> Sinus pressure <input type="checkbox"/> Visual changes	RESPIRATORY <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing
CARDIOVASCULAR <input type="checkbox"/> Chest pain <input type="checkbox"/> Pain while walking (Claudication) <input type="checkbox"/> Edema <input type="checkbox"/> Palpitations	GASTROINTESTINAL <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Blood in stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	GENITOURINARY <input type="checkbox"/> Painful urination (Dysuria) <input type="checkbox"/> Excessive amount of urine (Polyuria) <input type="checkbox"/> Urinary frequency
METABOLIC/ENDOCRINE <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Excessive thirst (Polydipsia) <input type="checkbox"/> Excessive hunger (Polyphagia)	NEUROLOGICAL <input type="checkbox"/> Dizziness <input type="checkbox"/> Extremity numbness <input type="checkbox"/> Extremity weakness <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors	PSYCHIATRIC <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression
INTEGUMENTARY <input type="checkbox"/> Breast discharge <input type="checkbox"/> Breast lump <input type="checkbox"/> Hives <input type="checkbox"/> Mole change(s) <input type="checkbox"/> Rash <input type="checkbox"/> Skin lesion	MUSCULOSKELETAL <input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Neck pain	HEMATOLOGIC <input type="checkbox"/> Easily bleeds <input type="checkbox"/> Easily bruises <input type="checkbox"/> Lymphedema <input type="checkbox"/> Issues with blood clots

Patient Signature

Date