Carolina BioOncology Institute
CANCER RESEARCH CLINIC

PATIENT DEMOGRAPHICS AND HEALTH HISTORY FORM

Name: _____Today's Date: _____

Address: _____

_____

City State Zip Code Country

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email _____

Date of Birth: _____ Social Security Number: _____

- ☐ Male
- ☐ Female

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:

_____

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Legally separated
- ☐ Life Partner
- ☐ Widowed

Occupation:

_____

Please list your primary caregiver (emergency contact) during treatment:	Do you have an Advance Directive?
Name: _____	☐ Yes
Relationship: _____	☐ No
Phone: _____	

Preferred Pharmacy: _____

Preferred Pharmacy Address: _____

Preferred Pharmacy Phone Number: _____

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

Medical History	
Diagnosis	**Date of Diagnosis**

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

☐ Yes, what symptom(s): _____

☐ No

Surgery/Procedure History	
Surgery/Procedure	Date Performed

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Name: _____Today's Date: _____

Gynecological History (for females)

Menopause Status:

☐ Pre

☐ Peri (still have periods, may or may not be regular)

Contraceptive, if any:

_____

☐ Post (no period for >12 consecutive months)

☐ Date of last menstrual period: _____

☐ Did you go through menopause before your cancer diagnosis?

☐ Yes; Date: _____

☐ No

☐ Unknown

Reason:

☐ Natural

☐ Removal ovaries, date: _____

☐ Removal uterus, date: _____

☐ Total hysterectomy, date: _____

☐ Other: _____

☐ Unknown:

Social History

Smoking Status:

☐ Yes, current every day smoker

☐ Since Date _____

☐ Yes, but quit (former smoker)

☐ Since Date _____

☐ # Packs/Day _____

☐ Quit Since Date _____

☐ Never smoker

Alcohol Consumption Status:

☐ Yes, current every day drinker

☐ Yes, current some day drinker

☐ # Drinks/day _____

☐ # Days/week _____

☐ Yes, but quit

☐ Quit Since Date ____

☐ Never

Hazardous Materials Exposure:

☐ Asbestos

☐ Benzene

☐ Coal

☐ Lead

☐ Mercury

☐ Radiation

☐ Petroleum products

☐ Xylene

☐ Other:

_____

_____

☐ None

History of Products, use of (select all that apply):

☐ Cigarettes

☐ Cigars

☐ Chewing tobacco

☐ Pipe

☐ Snuff

☐ Vape

☐ Marijuana

☐ Recreational drug use, specify: _____

☐ None

Support Systems:

☐ Lives with spouse, significant other, family, or friends

☐ Lives alone

☐ Lives in own house

☐ Lives in nursing home

☐ Lives in assisted living environment

☐ Supportive family/friends willing to assist with needs

☐ No support system exists

☐ Adequate transportation available for visits

☐ Transportation problems exist and will require assistance, please specify:_____

☐ Homeless

Activities:

☐ Sedentary

☐ Daily activities

☐ Occasional exercise

☐ Light exercise

☐ Regular exercise

☐ Extensive exercise

Nutrition:

☐ Regular meals

☐ Nutritional supplements

☐ Liquid diet

☐ Diabetic diet

☐ Vegetarian

☐ Tube feedings

☐ TPN

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Oncologic Family History **Please list all first-, second-, and third-degree family members with history of cancer.**				
Relationship to Patient	**Maternal**	**Paternal**	**Cancer Type**	**Health Status**
	☐	☐		☐ Alive ☐ Deceased
	☐	☐		☐ Alive ☐ Deceased
	☐	☐		☐ Alive ☐ Deceased
	☐	☐		☐ Alive ☐ Deceased
	☐	☐		☐ Alive ☐ Deceased
	☐	☐		☐ Alive ☐ Deceased

Select all that apply regarding family history

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

MRI Questionnaire	
Are you claustrophobic?	☐ Yes ☐ No
Do you have any electrical implants such as a Pacemaker, Defibrillator, or Stimulator?	☐ Yes ☐ No
Are there any metallic objects in the body, such as bullets, metal shavings or piercings?	☐ Yes ☐ No
Have you ever worked as a machinist, welder, or metal worker?	☐ Yes ☐ No
Have you ever been hit in the face or eye with metal or had metal removed from your eyes?	☐ Yes ☐ No
Are you allergic to MRI contrast?	☐ Yes ☐ No
Are you able to sit, stand or move onto the bed without assistance?	☐ Yes ☐ No
Do you have a stent?	☐ Yes ☐ No

Patient Signature: _____ Date: _____