

## Patient History Form

Please complete this form prior to arrival and present it to the nurses.

Thank you.

**Patient Information**

Patient Name (Last, First, MI)	Gender	Date of Birth
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Who completed this form?

- Patient  
  Family Member  
  Domestic Partner  
  Legal Guardian  
  Other

**Physician Information**

**Phone numbers**

Referring	(   )   -
Primary Care	(   )   -
Medical Oncologist	(   )   -
Surgeon	(   )   -

**Reason for Being Here Today**

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**Past Medical History – Please check all that apply**

- |   |   |
|---|---|
| <input type="checkbox"/> Alcoholism<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Arthritis/Joint pain<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Blood transfusions<br><input type="checkbox"/> Cancer /Dates<br>_____<br>_____<br>_____<br><input type="checkbox"/> Depression/Anxiety<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Kidney infections<br><input type="checkbox"/> Kidney stones<br><input type="checkbox"/> Seizures/convulsions<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Thyroid disease<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Jaundice<br><input type="checkbox"/> Other _____ |
|---|---|

**For Women:** Abnormal Pap Test  No  Yes  Unsure

Last Mammogram date: \_\_\_\_\_ Where? \_\_\_\_\_

Pregnancies: \_\_\_\_\_ Live Births: \_\_\_\_\_

Pregnant  No  Yes  Unsure

Any change in menstrual periods:  No  Post menopause  Post hysterectomy  Yes

Vaginal bleeding  No  Yes

Last menstrual period onset date \_\_\_\_\_

**For Men:** Last prostate exam \_\_\_\_\_

Abnormal prostate exam  No  Yes  Unsure

Vasectomy  No  Yes

**Past Surgeries**

Surgery	Reason	Date

**Past Radiation**Radiation  No  Yes When?

Which part of body?

Doctor's name and Office location?

**Past Chemotherapy**Chemo  No  Yes Date of last chemotherapy?

What type?

**Allergies**

List all medications, foods, dusts, fumes, and animals to which you have allergies.

Drug or Item	Reaction
Example: <i>Sulfa</i>	<i>rash</i>

**Medications**

Are you using any medications (prescription or over-the-counter), vitamins, herbal supplements, or contraceptives? If yes, please list below.

Name of Medication	Strength of Each dose	Number of Doses at a Time	Frequency
Example: <i>Amoxicillin</i>	<i>250 mg</i>	<i>1 pill</i>	<i>3 times daily</i>

**Social History** Married  Single  Widowed  OtherSmoking  No  Yes How much? How long?Drinking  No  Yes How much?Drugs  No  Yes What kind? How long?**Which of the following describes your living environment?** House  Apartment  Assisted living  Nursing home  Other \_\_\_\_\_**With whom do you live with?** Live alone  Spouse  Domestic partner  Family  Other \_\_\_\_\_

**Do you have assistance for your home care from family, friends, or others, should you require it?**  Yes  No

**Profession?**

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**Family History**

Condition	Yes	Relative
Alcoholism		
Breast Cancer		
Colon Cancer		
Diabetes		
High Blood Pressure		
Heart Disease		
Ovarian Cancer		
Stroke		
Other Cancer		

**Please check if any of the following symptoms apply to you currently**

**Constitutional**

- Weight Loss
- Weigh Gain
- Fever
- Fatigue

**Eyes**

- Double Vision
- Blurred Vision
- Vision Changes

**Ears, Nose, Throat**

- Ear aches
- Ringing in ears
- Sinus problems
- Sore throat
- Mouth sores
- Swallow difficulty
- Dental problems

**Breasts**

- Pain in breast
- Discharge
- Masses

**Musculoskeletal**

- Muscle weakness

**Hematologic/Lymphatic**

- Easy bruising
- Enlarged lymph nodes
- Easy bleeding

**Cardiovascular**

- Painful breathing
- Difficult breathing on exertion
- Leg swelling
- Heart palpitations

**Respiratory**

- Wheezing
- Spitting up blood
- Shortness of breath
- Cough, chronic

**Gastrointestinal**

- Frequent diarrhea
- Bloody stool
- Nausea/vomiting
- Constipation

**Endocrine**

- Dry skin
- Abnormal thirst
- Hot flashes

**Skin**

- Rash
- Ulcers

**Neurological**

- Dizziness
- Seizures
- Numbness
- Trouble walking

**Genitourinary**

- Blood in urine
- Pain with urination
- Urgency
- Frequency of urination
- Leaking urine
- Abnormal period
- Painful intercourse

**Psychiatric**

- Depression
- Frequent crying

**Other:**

**Diagnostic Tests**

Date	Test	Location	Ordering Physician
	Example: <i>CT Brain</i>	<i>Radiology Group in Mesa</i>	<i>Dr. Do Good</i>

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

## Nutritional Status

### Weight History

- I currently weigh about \_\_\_\_\_ pounds  
I am about \_\_\_\_ feet \_\_\_\_ inches tall  
1 month ago I weighed about \_\_\_\_\_ pounds  
6 months ago I weighed about \_\_\_\_\_ pounds  
During the past 2 weeks, weight was \_\_\_\_\_

### Food Intake

As compared to normal, rate food intake during the past month as either:

- more than usual     less than usual

Now taking:

- Normal food but less than usual  
 Little solid food  
 Only liquids  
 Very little, if anything  
 Nutritional supplements  
 Tube feeding \_\_\_\_\_ Formula \_\_\_\_\_ Number of cans \_\_\_\_\_

### Symptoms: During the past 2 weeks:

- No problems eating  
 No appetite  
 Nausea  
 Vomiting  
 Constipation  
 Diarrhea  
 Mouth sores  
 Dry mouth  
 Pain - Where? \_\_\_\_\_  
 Things taste funny  
 Smells bother me

### Physical Activity: Over the past month, rate activity as:

- Normal, no limitations  
 Not my normal self, but able to be up and about with fairly normal activities  
 Not feeling up to most things, but in bed less than half the day  
 Able to do little activity and spend most of the day in bed or chair  
 Pretty much bedridden, rarely out of bed