Patient Reported History

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

Instructions: Please answer these questions as accurately as possible. This will help your physician evaluate your illness. All information is confidential and will not be released without your written permission.

List of Chronic Medical Illnesses or Problems

Have you ever had any of the following?	Yes	No	Have you ever had any of the following?	Yes	No
Prior Cancers – Type			Kidney Failure		
Angina			Kidney Stones		
Heart Attacks			Cystitis or Bladder Infections		
Heart Failure			Prostatitis (Men Only)		
Irregular Heart Beat			***Have you had more than 2 episodes within 3 years:***		
Heart Murmur			TURP (Men Only) ***If Yes, date of TURP _____***		
Arthritis			Other Urological Operations/Procedures ***If Yes, please list in "surgeries" section below***		
High Blood Pressure ***If Yes, year of onset _____***			BPH/Enlarged Prostate		
Elevated Cholesterol			Lupus		
Stroke or Paralysis			Scleroderma		
Asthma			Other Collagen Vascular Disease		
Anemia			Blood Clots or Clotting Disorder		
Chronic Bronchitis/Emphysema			Tuberculosis		
Hernia ***If Yes, please circle: Inguinal? Hiatal?***			HIV or AIDS		
Diverticular Disease			Diabetes ***If Yes, year of onset _____***		
Hemorrhoids			Thyroid Disease or Goiter		
Rectal Bleeding			Glaucoma/Cataracts		
Ulcers of Stomach or Small Intestine			Seizures or Epilepsy		
Gallbladder Disease			Parkinson's Disease		
Hepatitis or Liver Disease			Multiple Sclerosis		
Pancreatitis			Other Neurologic Problems		
Crohn's Disease			Skin Condition(s)		
Colitis			Severe Anxiety		
Irritable Bowel Syndrome					

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

Medical History:

Do you have a pacemaker or internal defibrillator?	☐ **Yes**	☐ **No**
Have you ever had hip surgery?	☐ **Yes**	☐ **No**

Surgeries, Procedures & Hospitalizations

Type of Procedures or Hospitalizations	Where	Year

Important: Prior Cancer Treatments

Have you ever had any radiation (ex: seeds, cobalt, external radiation, radioisotopes including treatment for birthmarks, acne, cancer etc.?)
☐ Yes ☐ No
If Yes, where (name of institution) was this performed, what for, and when?

Have you ever received Chemotherapy? ☐ Yes ☐ No
If Yes, what drugs and when?

Have you received hormone therapy for cancer? ☐ Yes ☐ No
If Yes, what drugs (i.e. Tamoxifen, Femara, Lupron, Casodex)?

Hormone Therapy Name/Dose/Frequency	Date

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

For Women: (Gynecological History)

Menarche (First Menstrual Period)(Age):_____ Last Menstrual Period (Date): _____
How many days does the period usually last: _____ Age at menopause: _____

Are you or could you be pregnant? ☐ Yes ☐ No Age at first pregnancy? _____

Pregnancies (Number): _____ Miscarriage (Number): _____ Deliveries (Number): _____

Are you currently on Birth Control: ☐ None ☐ Yes, if so what _____

Did you ever take hormones (i.e. estrogen, birth control pills, androgens, etc.)? ☐ Yes ☐ No

If yes, how long? _____

Medications

List the medications you are presently taking, including OTC, Vitamins and Supplements:

Prescription	Dosage	Frequency	For What?

Allergies (Drug, Food, Iodine etc.)

Do you have any allergies? ☐ Yes ☐ No

If Yes, what are you allergic to and what type of reaction do you get?

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

Family History

Relation	Age	Medical Problems	If Deceased, Age and Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			
Comments:			

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Partnered

Spouse/Partner's Name: _____

Patient Occupation: _____

Work Situation: ☐ Full Time ☐ Part Time ☐ Medical Leave ☐ Disability ☐ Retired

Did you ever work in an occupation that involved exposure to cancer causing chemicals, fumes or other carcinogens? ☐ Yes ☐ No

What? _____ For how many years? _____

Living Situation: ☐ House ☐ Apartment ☐ Mobile Home ☐ Who lives with you? _____

Transportation: ☐ Able to drive self ☐ Driver required

Do you follow any special diet? ☐ Regular ☐ Vegan/Vegetarian ☐ Renal ☐ Diabetic

Patient Name:_____ Medical Record #: _____

Form Completion Date:_____

REVIEW OF SYSTEMS

Please circle any of the following symptoms <u>that you are currently experiencing</u>. If you do not have any of the listed symptoms in each section, please circle [NONE] at the top of each section.

<u>GENERAL/CONSTITUTIONAL</u>: **If none of the following apply, circle here [NONE]**

Loss of Appetite	Fatigue	Fever	Night Sweat
Chills/Rigors/Tremors	Problems Sleeping	Dizziness	

Weight Loss/Change: If yes, _____ pounds over _____ months. Intentional? _____

<u>EYES</u>: **If none of the following apply, circle here [NONE]**

Blurred Vision	Double Vision	Increased Tearing	Night Blindness
Sensitivity to Light	Visual Difficulties		

<u>HEAD & NECK (ENTM)</u>: **If none of the following apply, circle here [NONE]**

Difficulty Swallowing	Ear pain	Nose Bleeds	Painful Swallowing
Difficulty Hearing	Mouth Dryness	Bleeding in Mouth	Ear Infections
Sinusitis	Sputum Production	Mouth Sores	Taste Alterations
Ringing in the Ears	Masses or Lumps		

<u>SKIN</u>: **If none of the following apply, circle here [NONE]**

Hair Loss	Blisters	Bruising	Dry Skin
Facial Burning	Nail Changes	Sensitivity to Sun	Itching
Rash	Hives		

<u>BREAST</u>: **If none of the following apply, circle here [NONE]**

Lump or Mass in Breast	Nipple Discharge	Nipple Inversion	Pain in Breast

<u>CARDIOVASCULAR</u>: **If none of the following apply, circle here [NONE]**

Irregular Heartbeat	Chest Pain	Shortness of Breath	Edema/Swelling of Feet
Sleep Sitting or Propped up	Palpitations		

<u>RESPIRATORY</u>: **If none of the following apply, circle here [NONE]**

Cough Cough Up Blood: How Long?_____ Cough Up Sputum: Color?_____

Hiccoughs	Difficult/Painful Breathing	Wheezing	Chest Wall Pain

Are you able to lie flat? ☐ Yes ☐ No Oxygen Use _____ L/min

Shortness of Breath on Exertion: What Activity causes or makes it worse?_____

Patient Name:_____ Medical Record #: _____

Form Completion Date:_____

GASTROINTESTINAL: **If none of the following apply, circle here [NONE]**

Abdominal Pain/Cramping | Change in Bowel Habits | Constipation | Diarrhea

Heartburn/Dyspepsia | Vomiting Blood | Symptomatic hemorrhoids

Bloody Stools/ Black Stools/GI Bleeding | Nausea | Satiety/Feel Full Quickly | Vomiting

GENITOURINARY: **If none of the following apply, circle here [NONE]**

Pain or Burning on Urination | Frequent Urination | Blood in Urine | Impotence

Leakage or Loss of Bladder Control | Get up at Night to Urinate: How Often? _____

Kidney Stones | Urgent Urination | Change in Sexual Function

MUSCULO-SKELETAL: **If none of the following apply, circle here [NONE]**

Arthritis | Bone Pain | Painful Joints | Weak Muscles

Decreased Range of Motion

NEUROLOGIC: **If none of the following apply, circle here [NONE]**

Disorientation | Dizziness | Gait Changes | Frequent Headaches

Difficulty Sleeping | Memory Loss | Numbness or Tingling: Where? _____

Weakness in Part of Body: Where? _____ | Seizure | Sensory Problems

Stroke | Claustrophobia

PSYCHIATRIC: **If none of the following apply, circle here [NONE]**

Delusions | Hallucinations | Depression | Change in Personality

Mood Swings

If you check yes to any of these, how long have you had these problems? _____

Have you seen other doctors for these problems? _____

ENDOCRINE: **If none of the following apply, circle here [NONE]**

Diabetes | Hot Flashes | Menstrual Irregularities | Thyroid Disease

HEMATOLOGICAL/LYMPHATIC: **If none of the following apply, circle here [NONE]**

Excessive Bruising | Swollen Lymph Glands

OB-GYN (For Women): **If none of the following apply, circle here [NONE]**

Unusual Vaginal Bleeding | Unusual Vaginal Discharge | Painful/Difficult Intercourse

Vaginal Spotting