Patient Health History

Name: _____ Date of Birth: _____ Age: _____

SS #: _____ Today's Date: _____ Sex: Male ☐ Height: _____

Gender Identity: Female ☐

☐ Man ☐ Woman ☐ Transgender Male (man) ☐ Transgender female (woman) ☐ Genderqueer/Non-binary ☐ Choose not to disclose

Pronouns: ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other ☐ Choose not to disclose

Religious preference (ex. Christianity, Islam, Judaism, etc.): _____ ☐ Choose not to disclose

Primary Care Physician: _____ Phone Number: _____

Referring MD: _____ Phone Number: _____

Other MD's (Name/Specialty): _____ Phone Number: _____

Behavioral Health Provider: _____

Pharmacy Name: _____ Pharmacy Number: _____

Current problem or reason for consultation: _____

PAST MEDICAL HISTORY: *Please check all the boxes that apply*

Allergies	☐	Hepatitis/Liver Disease	☐
Anemia/Blood Disorders	☐	Hypercholesterolemia	☐
Arthritis	☐	Hypertension	☐
Asthma	☐	Irregular Heartbeat	☐
Blood Clots	☐	Kidney Disease	☐
Cancer	☐	Pancreatitis	☐
Cataracts	☐	Sickle Cell Disease	☐
Colitis	☐	Sinusitis	☐
Diabetes	☐	Stroke	☐
Emphysema	☐	Thyroid	☐
GERD	☐	Tuberculosis	☐
Glaucoma	☐	Ulcers	☐
Heart Disease	☐		

Other: _____

Other: _____

Any unusual childhood infections or illnesses? _____

OPERATIONS: *Please list year, operation and surgeon (if known)*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ROUTINE CANCER SCREENING TESTS:

Mammogram: _____

Breast Exam: _____

Pap Smear/Pelvic Exam: _____

Stool for Occult Blood: _____

Prostate Exam/PSA: _____

Chest X-Ray: _____

Colonoscopy/Sigmoidoscopy: _____

ALLERGIES TO MEDICATIONS: Yes ☐
No ☐

NAME OF DRUG(S)/TYPE OF REACTION:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS AND NUTRITIONAL SUPPLEMENTS:

NAME OF DRUG	DOSE (mg or mcg)	HOW MANY TIMES DAILY	HOW LONG (MONTH/YEARS)

Vaccinations (Please provide date of last vaccination):

Pneumonia
1st shot: _____
2nd shot: _____

Shingles
1st shot: _____
2nd shot: _____

COVID Vaccine
☐ J & J
☐ Moderna
☐ Pfizer

1st shot: _____
2nd shot: _____
3rd shot: _____

Influenza: _____

FAMILY HISTORY:

Relative	Age, If Living	Health Problems	If Deceased, list cause
Father			
Mother			
Sis/Bro			
Sis/Bro			
Sis/Bro			
Sis/Bro			
Sis/Bro			

For other relatives such as grandparents, aunts and uncles: *Please check all boxes that apply*

Anemia	☐	Diabetes	☐
Blood Clots	☐	Heart Disease	☐
Blood Disorders	☐	Hypertension	☐
Cancer	☐	Stroke	☐

Approximately 10% of cancer is hereditary. If you are concerned your family may be at risk, genetic counseling may be appropriate for you.

Would you like to discuss this with your physician? Yes ☐ No ☐

REVIEW OF SYSTEMS: *Please check all boxes that apply*

GENERAL	FEVER	☐	WEIGHT LOSS	☐	FATIGUE	☐
	CHILLS	☐	WEIGHT GAIN	☐	NIGHT SWEATS	☐
HEAD	HEADACHES	☐	RINGING IN EARS	☐	TOOTHACHE	☐
	BLACKOUTS	☐	SINUSITIS	☐	DOUBLE VISION	☐
	SEIZURES	☐	POST NASAL DRIP	☐	BLURRED VISION	☐
	DIZZINESS	☐	SORE THROAT	☐	CATARACTS	☐
	HEARING LOSS	☐	HOARSENESS	☐	GLAUCOMA	☐
	EARACHE	☐	SORE TONGUE	☐	LAST EYE EXAM_____	
	BLEEDING GUMS	☐	NOSEBLEEDS	☐		
CHEST	COUGH	☐	SHORTNESS OF BREATH	☐	HEART MURMUR	☐
	SPUTUM	☐	CHEST PAIN	☐	RHEUMATIC FEVER	☐
	COUGHING UP BLOOD	☐	PALPITATIONS	☐	HIGH BLOOD PRESSURE	☐
	WHEEZING	☐	SWELLING OF FEET	☐	LAST CHEST X-RAY _____	
	BRONCHITIS	☐	ASTHMA	☐		
NECK	LUMPS	☐	GOITER	☐	PAIN OR STIFFNESS	☐
BREAST	LUMPS	☐	PAIN	☐	NIPPLE DISCHARGE	☐
ABDOMEN	NAUSEA	☐	ABDOMINAL PAIN	☐	CONSTIPATION	☐
	VOMITING	☐	HIATAL HERNIA	☐	DIARRHEA	☐
	PAIN WHEN SWALLOWING	☐	ULCER	☐	HEMORRHOIDS	☐
	DIFFICULTY SWALLOWING	☐	GAS	☐	BLOOD IN STOOLS	☐
	INDIGESTION	☐	BLOATING	☐	BLACK STOOLS	☐

CONTINUE REVIEW OF SYSTEMS: *Please check all boxes that apply*

URINARY/GYN	BLOOD IN URINE	☐	# OF PREGNANCIES _____				
	BURNING WITH URINATION	☐	# OF MISCARRIAGES _____		SPOTTING	☐	
	FREQUENT URINATION	☐	# OF ABORTIONS _____		CRAMPING	☐	
	DIFFICULTY STARTING TO URINATE	☐	# OF CHILDREN _____		DISCHARGE	☐	
	BLADDER/ KIDNEY INFECTIONS	☐	LAST MENSTRUAL PERIOD _____		VAGINAL INFECTIONS	☐	
	GETTING UP AT NIGHT TO URINATE	☐	DURATION _____		LAST PAP SMEAR _____		
	SENSE OF FULL BLADDER	☐	INTERVAL _____				
SKIN	RASH	☐	ITCHING	☐	CHANGE IN HAIR OR NAILS	☐	
NEURO-MUSCULAR	JOINT STIFFNESS	☐	SWELLING	☐	NIGHT CRAMPS	☐	
	JOINT PAIN	☐	BACK PAIN	☐	VARICOSE VEINS	☐	
HEMATOLOGICAL	EASY BRUISING OR BLEEDING	☐	ANEMIA	☐	PAST INFUSION	☐	
					TRANSFUSION REACTIONS	☐	
ENDOCRINE	THYROID PROBLEMS	☐	HOT OR COLD INTOLERANCE	☐	EXCESSIVE THIRST OR HUNGER	☐	
PSYCHIATRIC	ANXIETY	☐	DEPRESSION	☐	MEMORY LOSS	☐	
	PANIC ATTACKS	☐	SUICIDAL THOUGHTS	☐	INSOMNIA	☐	

SOCIAL HISTORY:

Sexual Orientation: ☐ Heterosexual ☐ Bisexual ☐ Lesbian or gay ☐ Chose not to disclose

Other (please describe):

Marital Status: _____

Number of Children: _____ Age/Sex of Children: _____

Are you or could you currently be pregnant? ☐ Yes ☐ No ☐ N/A

Do you plan on having children in the future ? ☐ Yes ☐ No ☐ N/A

Would you like to discuss fertility preservation? ☐ Yes ☐ No ☐ N/A

Spouse Name: _____

Spouse Occupation: _____

Patient Occupation: _____

Highest Level of Education: _____

Patient Lives With: Self ☐ Child ☐
Spouse ☐ Parent(s) ☐
Sibling(s) ☐ Friend ☐
Other ☐ _____

Smoking History

Cigarettes ☐ How Many Years?_____
Cigars ☐ Number Per Day _____
Pipe ☐ If Quit, When? _____

Alcohol History

Beer ☐ How Many Years?_____
Wine ☐ How Much Per Day/Week/Month? _____
Liquor ☐ If Quit, When? _____

Recreational Drug Use ☐ Blood Transfusions ☐ HIV Testing ☐
Marijuana ☐ Do you have a medical marijuana card? ☐ YES ☐ NO
If so, who is your prescriber? _____

SUPPORT SERVICES:

Have you completed an advance directive? ☐ YES ☐ NO

Have you completed a living will? ☐ YES ☐ NO

Have you completed a medical power of attorney? ☐ YES ☐ NO

Do you have a need that you would like to discuss with a social worker? ☐ YES ☐ NO

Do you forsee TRANSPORTATION to be an issue when going to and from appointments? ☐ YES ☐ NO

Do you have financial concerns that you would like to discuss with a patient benefits representative? ☐ YES ☐ NO

PATIENT SIGNATURE: _____

PHYSICIAN SIGNATURE: _____

Personal and Family History of Cancer **Name Patient:** **DOB:**

Please read this information carefully before completing the attached family history questionnaire.
We are interested in learning as much as possible about any history of cancer in your family. Information that is necessary when assessing a family history of cancer includes:

WHO? Which relatives have had cancer and how are they related to you?
WHAT? What type(s) of cancer did the relative have?
AGE? How old was the relative when they were diagnosed?

Instructions:

1) **Please fill in the family history form as completely as you can, including relatives who have had cancer AND those who have not.**
2) **Our assessment of your family history is most accurate if you can provide us with as much detailed information as possible. We encourage you to talk with your family members and to obtain medical records confirming cancer diagnoses whenever possible.**

Have you ever had cancer? Yes ____ No ____ If yes, what type? _____

Age and year of diagnosis _____

What type of treatment did you have?_____

_____

At what hospital were you diagnosed and treated? _____

Your immediate family (If additional space is needed, please copy this page.)

Name of Individual	Male or Female	Date of birth or age	Date of death or age	Cause of Death	Affected with cancer? If yes, what type of cancer?	Age/date of cancer diagnosis	Does this person have children?
Your children 1.							#Sons ____ #Daughters ____
2.							#Sons ____ #Daughters ____
3.							#Sons ____ #Daughters ____
4.							#Sons ____ #Daughters ____
5.							#Sons ____ #Daughters ____
6.							#Sons ____ #Daughters ____

Your immediate family (If additional space is needed, please copy this page.)

Please mark individuals with an * if a half-sister or half-brother.

Name of Individual	Male or Female	Date of birth or age	Date of death or age	Cause of Death	Affected with cancer? If yes, what type of cancer?	Age/date of cancer diagnosis	Does this person have children?	Have any of their children had cancer? If yes, use space below grid.
Your mother								
Your father								
Your brothers and sisters 1.							#Sons ____ #Daughters ____	
2.							#Sons ____ #Daughters ____	
3.							#Sons ____ #Daughters ____	
4.							#Sons ____ #Daughters ____	
5.							#Sons ____ #Daughters ____	
6.							#Sons ____ #Daughters ____	

Complete the space below only if any children of individuals listed on this page have had cancer (your nieces and nephews).

* Name of Niece or Nephew Name of Parent Current Age or Age of Death Type of Cancer Age at diagnosis

Your mother's family (If additional space is needed, please copy this page.)

Please mark individuals with an * if a half-sister or half-brother of your mother.

Name of Individual	Male or Female	Date of birth or age	Date of death or age	Cause of Death	Affected with cancer? If yes, what type of cancer?	Age/date of cancer diagnosis	Does this person have children?	Have any of their children had cancer? If yes, use space below grid.
Your grandmother								
Your grandfather								
Your mother's siblings 1.							#Sons ____ #Daughters ____	
2.							#Sons ____ #Daughters ____	
3.							#Sons ____ #Daughters ____	
4.							#Sons ____ #Daughters ____	
5.							#Sons ____ #Daughters ____	
6.							#Sons ____ #Daughters ____	

Complete the space below only if any children of individuals listed on this page have had cancer (your first cousins).

* Name of Cousin Name of Parent Current Age or Age of Death Type of Cancer Age at diagnosis

Your father's family (If additional space is needed, please copy this page.)

Please mark individuals with an * if a half-sister or half-brother of your father..

Name of Individual	Male or Female	Date of birth or age	Date of death or age	Cause of Death	Affected with cancer? If yes, what type of cancer?	Age/date of cancer diagnosis	Does this person have children?	Have any of their children had cancer? If yes, use space below grid.
Your grandmother								
Your grandfather								
Your father's siblings 1.							#Sons ____ #Daughters ____	
2.							#Sons ____ #Daughters ____	
3.							#Sons ____ #Daughters ____	
4.							#Sons ____ #Daughters ____	
5.							#Sons ____ #Daughters ____	
6.							#Sons ____ #Daughters ____	

Complete the space below only if any children of individuals listed on this page have had cancer (your first cousins).

* Name of Cousin Name of Parent Current Age or Age of Death Type of Cancer Age at diagnosis

Other family members who have had cancer (If additional space is needed, please copy this page.)

List name and relationship to you.	Male or Female	Date of birth or age	Date of death or age	Cause of Death	Affected with cancer? If yes, what type of cancer?	Age/date of cancer diagnosis
1.						
2.						
3.						
4.						
5.						
6.						