

Patient Health History



Name: _____ Date of Birth: _____ Age: _____

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

Gender Identity: Female

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

Preferred pronoun (ex. he/him/they, she/her/they, they): _____ Other: _____

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 | <input type="checkbox"/> | Hepatitis/Liver Disease | <input type="checkbox"/> |
| Anemia/Blood Disorders | <input type="checkbox"/> | Hypercholesterolemia | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Irregular Heartbeat | <input type="checkbox"/> |
| Blood Clots | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Pancreatitis | <input type="checkbox"/> |
| Cataracts | <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> |
| Colitis | <input type="checkbox"/> | Sinusitis | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | Thyroid | <input type="checkbox"/> |
| GERD | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | | |

Other: _____

Other: _____

Any unusual childhood infections or illnesses? _____

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

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

CONTINUE REVIEW OF SYSTEMS: Please check all boxes that apply

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

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 foresee 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 | | | | | | | #Sons _____ #Daughters _____ |
| 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 | | | | | | | #Sons ____ #Daughters ____ | |
| 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 | | | | | | | #Sons ____ #Daughters ____ | |
| 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. | | | | | | |