Patient Health History

Virginia Oncology Associates

Name: _____ Date of Birth: _____ Age: _____

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

Gender Identity:

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

Approximately 10% of cancers are hereditary. If you are concerned that 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	☐	POSTNASAL DRIP	☐	BLURRED VISION	☐		
	DIZZINESS	☐	SORE THROAT	☐	CATARACTS	☐		
	HEARING LOSS	☐	HOARSENESS	☐	GLAUCOMA	☐		
	EARACHE	☐	SORE TONGUE	☐				
	BLEEDING GUMS	☐	NOSEBLEEDS	☐	LAST EYE EXAM_____			
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 ☐ BURNING WITH URINATION ☐ FREQUENT URINATION ☐ DIFFICULTY STARTING TO URINATE ☐ BLADDER/ KIDNEY INFECTIONS ☐ GETTING UP AT NIGHT TO URINATE ☐ SENSE OF FULL BLADDER ☐	# OF PREGNANCIES _____ # OF MISCARRIAGES _____ # OF ABORTIONS _____ # OF CHILDREN _____ LAST MENSTRUAL PERIOD _____ DURATION _____ INTERVAL _____	SPOTTING ☐ CRAMPING ☐ DISCHARGE ☐ VAGINAL INFECTIONS ☐ LAST PAP SMEAR _____
SKIN	RASH ☐	ITCHING ☐	CHANGE IN HAIR OR NAILS ☐
NEURO-MUSCULAR	JOINT STIFFNESS ☐ JOINT PAIN ☐	SWELLING ☐ BACK PAIN ☐	NIGHT CRAMPS ☐ 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 ☐ PANIC ATTACKS ☐	DEPRESSION ☐ SUICIDAL THOUGHTS ☐	MEMORY LOSS ☐ INSOMNIA ☐

SOCIAL HISTORY:

Sexual Orientation: ☐ Heterosexual ☐ Bisexual ☐ Lesbian or gay ☐ Choose 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: _____

Questions regarding bloodless care:

Do you consent to a blood transfusion? ☐ Yes ☐ No

If a blood transfusion were needed to save my life, would I accept it? ☐ Yes ☐ No

Would you like to be enrolled in bloodless care? ☐ Yes ☐ No

If no, reason for declining blood (religious or other): _____

Is there a designated healthcare decision maker who understands your wishes regarding blood transfusion? ☐ Yes ☐ No

Patient lives with: Self ☐ Child ☐ Other ☐
Spouse ☐ Parent(s) ☐
Siblings(s) ☐ Friend ☐

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: _____