HIGHLANDS ONCOLOGY GROUP

Highlands Oncology
Patient History

Name (First and Last) _____ Today's Date:_____

Date of Birth: _____ Referring Physician: _____

☐ Male ☐ Female Primary Care Physician: _____

OB/Gyn Physician: _____

Other Physicians: _____

Reason for Today's Visit: _____

_____

Personal Medical History: Please check all that apply and include year of diagnosis

		Date of Diagnosis	Doctor
☐	Alcohol dependence		
☐	Anemia		
☐	Angina/chest pain		
☐	Anxiety		
☐	Asthma		
☐	Blood disorder Type_____		
☐	Cancer Type_____		
☐	Cardiac Stent		
☐	Cirrhosis, due to alcohol		
☐	Colostomy/ileostomy		
☐	Coronary artery disease		
☐	Congestive heart disease/CHF		
☐	Chronic obstructive pulmonary disease/COPD		
☐	Depression		
☐	Diabetes Type_____		
☐	Dialysis		
☐	Drug dependence, Drug name_____		
☐	Emphysema		
☐	GERD		
☐	Heart arrhythmia		
☐	Heart attack/MI		

		Date of Diagnosis	Doctor
☐	Heart valve disease		
☐	Hepatitis,Type_____		
☐	High blood pressure		
☐	High cholesterol		
☐	HIV/AIDS		
☐	Inflammatory bowel disease		
☐	Kidney disease/renal failure, Stage_____		
☐	Neuropathy		
☐	Organ transplant, Type _____		
☐	Pacemaker		
☐	Parkinson's disease		
☐	Paralysis		
☐	Pneumonia		
☐	Rheumatoid arthritis		
☐	Schizophrenia		
☐	Seizure disorder		
☐	Stroke		
☐	Thyroid disease		
☐	Tuberculosis		
☐	Ulcer Type_____		
☐	Vertebral fractures		
☐	Other_____		

Hospitalizations/Surgeries: Please list all hospitalizations and surgeries

	Date	Reason for Hospitalization or Type of Surgery	Where	Doctor
1.				
2.				
3.				
4.				
5.				
6.				

Previous Treatment for Cancer (if applicable) When, Where

Radiation Therapy: _____

Chemotherapy: _____

Hormone Therapy:_____

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Immunizations: Please check previous immunizations received and include date of last vaccine if known.

Flu ☐	Hepatitis B ☐
Shingles ☐	Pneumonia ☐

Medications: Please list current prescriptions and over-the-counter medications, as well as herbals, supplements and vitamins.

	Medication	Dose	Frequency	Start Date	Reason
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					

Pharmacy Name and location _____

Allergies

Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list the medications that you are allergic to and the type of reaction:

_____
_____
_____
_____

Are you allergic to:

Contrast/IV dye for scans ☐ Yes ☐ No
Latex: ☐ Yes ☐ No
Tape: ☐ Yes ☐ No
Vaccines: ☐ Yes ☐ No If yes, please list the type of vaccine: _____
Other allergies: ☐ Yes ☐ No
If yes, please list other allergies: _____

Blood Transfusions

Have you ever had a blood transfusion? ☐ Yes ☐ No Reason: _____
If yes, did you have a reaction? ☐ Yes ☐ No
Date of last blood transfusion: _____

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Screenings

	Date	
Last mammogram (female)		
Last PAP smear (female)		
Last colonoscopy or sigmoidoscopy		
Last bone density scan		
Other		

Social History

Living arrangement: ☐ Single ☐ Married ☐ Partnered ☐ With family ☐ Separated ☐ Divorced ☐ Widowed ☐ Care Facility

Number of pregnancies _____ Number of children:_____

Occupation (previous if retired): _____ ☐ Retired

Have you served in the military? ☐ Yes ☐ No If yes, dates of service _____

Do you currently use tobacco products:

☐ Yes Number per day: ☐ Cigarettes: _____ ☐ Cigars:_____ ☐ Pipe:_____ ☐ Chewing tobacco:_____

For how many years have you used the above tobacco product? _____

No ☐ Have you ever used tobacco products in the past? ☐ Yes ☐ No

When did you quit? _____ For how many years did you use tobacco products? _____

How many servings of wine, beer or other alcoholic beverage(s) do you drink per day? _____Per week?_____

Do you have a history of alcoholism? ☐ Yes ☐ No

Have you used illegal drugs? ☐ Yes ☐ No

If yes, which ones? _____

Do you use marijuana? ☐ Yes ☐ No

What do you do for exercise?_____How many times per week? _____

Do you have an Advance Directive, Living Will, or Power of Attorney? ☐ Yes ☐ No

If you have one of these, please bring to your next appointment

Family history of cancer

	Type of Cancer	Age at Diagnosis	Alive or Deceased
Father			
Mother			
Brother			
Sister			
Son			
Daughter			
Grandfather			
Grandmother			
Uncle			
Aunt			

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Symptoms: Please check all that apply or *None*

Do you have pain? ☐ Yes ☐ No
If yes, where? _____ Intensity (1-10): _____ Frequency: _____

Constitutional:
- ☐ Appetite
  - ☐ Good
  - ☐ Fair
  - ☐ Poor
- ☐ Weight loss
- ☐ Fatigue
- ☐ Generalized weakness
- ☐ Fever
- ☐ Altered taste
- ☐ Chills
- ☐ Night sweats
- ☐ Hot flashes
- ☐ None

Immunologic/Infections:
- ☐ Severe allergic reactions
- ☐ Frequent or severe infections
- ☐ Pollen allergies/hay fever
- ☐ None

Hematologic/Lymphatic:
- ☐ Easy bruising
- ☐ Abnormal bleeding
- ☐ Enlarged lymph nodes
- ☐ None

Eyes:
- ☐ Glasses/contacts
- ☐ Blurred vision
- ☐ Double vision
- ☐ Dry eyes
- ☐ None

Ears, nose, mouth, throat:
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sinus tenderness
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Bleeding gums
- ☐ Mouth sores
- ☐ Dry mouth
- ☐ None

Cardiovascular/Heart:
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swollen feet, ankles or hands
- ☐ None

Respiratory/Lungs:
- ☐ Cough
- ☐ Sputum or phlegm production
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ None

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Difficulty swallowing
- ☐ Frequent heartburn
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stools
- ☐ Change in bowel habits
- ☐ Hemorrhoids
- ☐ None

Genitourinary:
- ☐ Pain/burning with urination
- ☐ Excessive nighttime urination
- ☐ Slow starting or stopping
- ☐ Urgency
- ☐ Unable to hold urine
- ☐ Blood in the urine
- ☐ None

Gynecologic:
- ☐ Vaginal dryness
- ☐ Vaginal bleeding
- ☐ Vaginal discharge
- ☐ Pelvic pain

GYN History:
- ☐ First menstrual peroid, age _____
- ☐ Menopause, age _____
- ☐ Number of pregnancies _____
- ☐ Number of live births _____
- ☐ Estrogen use Yes ___ , No ___
  Number of years _____
- ☐ Contraception, type used
  _____

Musculoskeletal:
- ☐ Bone pain
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Swollen joints
- ☐ Back pain
- ☐ Limited range of motion
- ☐ None

Integumentary/Skin:
- ☐ Rash
- ☐ Itching
- ☐ A sore that won't heal
- ☐ Dry skin
- ☐ None

Neurological:
- ☐ Headaches
- ☐ Seizures
- ☐ Poor coordination
- ☐ Weakness of arms or legs
- ☐ Paralysis
- ☐ Tremor
- ☐ Numbness in arms or legs
- ☐ Dizziness
- ☐ None

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Trouble sleeping/insomnia
- ☐ Memory loss
- ☐ Confusion
- ☐ None

Endocrine:
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive sweating
- ☐ Increased thirst
- ☐ None

Breasts:
- ☐ Breast mass
- ☐ Breast tenderness
- ☐ Nipple discharge
- ☐ Breast skin changes
- ☐ None