HIGHLANDS ONCOLOGY

Patient Medical History

Name (First & Last)____ Date of Birth ____/_____/_____

Additional Providers:

Primary Care Physician: ________________________________ OB/GYN:____________________________________

Other Providers:____

Preferred Pharmacy: Name:________________________________ Location:_______________________________

Allergies: Are you allergic to any medications? YES ☐ NO ☐ *If you indicated yes*, please list below:

____

____

Are you allergic to: ☐ Contrast/IV dye ☐ Latex ☐ Tape ☐ Vaccines (*Which one?*) ____________________

Hospitalizations and Surgeries:

Date	Surgery/Reason for Hospitalization	Location	Doctor

Previous Treatment for Cancer (*If applicable*) Please provide date and location of treatment center.

Radiation/Chemotherapy:____

Screenings:

(*Please check "**N**" if you have no history of listed screening.*)

Type	Date	N	Type	Date	N
Last Mammogram		☐	Last Pap Smear		☐
Last Colonoscopy		☐	Last Bone Density Scan		☐
Last EGD		☐	Other:		☐

Medications, Vitamins and Supplements

Medication Name	Dose	Frequency	Start Date	For the treatment of:

Immunizations:

(Please check "N" if you have no history of listed immunization)

Vaccine	Date	N	Vaccine	Date	N
Influenza		☐	Covid 19 ☐ Pfizer ☐ Moderna ☐ J & J		☐
Pneumonia		☐	Shingles		☐
Hepatitis B		☐			☐

Family History

List disease with age at time of diagnosis. Please check box if family member is deceased.

	Disease	Age			Disease	Age	
Father			☐	Mother			☐
Grandfather			☐	Grandmother			☐
Brother			☐	Sister			☐
Uncle			☐	Aunt			☐
Son			☐	Daughter			☐

Personal Medical History

		Date	Physician
☐	Alcohol Dependence		
☐	Anemia		
☐	Angina/Chest Pain		
☐	Anxiety		
☐	Asthma		
☐	Blood Disorder		
☐	Cancer		
☐	Cirrhosis		
☐	Colostomy/Ileostomy		
☐	Coronary Artery Disease		
☐	Congestive Heart Failure		
☐	COPD		
☐	Depression		
☐	Diabetes Type:		
☐	Drug Dependence		
☐	GERD/Heartburn/Reflux		
☐	Cardiac Arrhythmia		
☐	Heart Attack		

		Date	Physician
☐	Heart Valve Disease		
☐	Hepatitis Type:		
☐	High Blood Pressure		
☐	High Cholesterol		
☐	HIV/ AIDS		
☐	Inflammatory Bowel Disease		
☐	Kidney Disease Stage:		
☐	Neuropathy		
☐	Organ Transplant Type:		
☐	Parkinson's Disease		
☐	Paralysis		
☐	Pneumonia		
☐	Rheumatoid Arthritis		
☐	Schizophrenia		
☐	Seizure Disorder		
☐	Stroke		
☐	Thyroid Disease		
☐	Ulcer		

Social History

Marital Status:☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Children?:** ☐ Yes☐ No #_____

Living: ☐ With family ☐ Alone ☐ Care Facility **Occupation:** ______________________________________

Do you drink alcoholic beverages? ☐ Yes ☐ No *If yes*, how many? Daily___ Weekly ___ Monthly ___

Have you used illegal drugs? ☐ Yes ☐ No *If yes*, which ones? ____________________________________

Do you use Marijuana? ☐ Yes ☐ No *If yes*, do you have a Medical Marijuana card? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No *If yes*, please list reason: _______________________

Most recent transfusion date: ________________________ Adverse reaction: ☐ Yes ☐ No

**__Female patient only:__ Are you currently pregnant? ☐ Yes ☐ No Do you use contraception? ☐Yes ☐No

Have you used Estrogen? ☐ Yes ☐ No ☐ Currently *If yes*, for how long? _____ yrs. Year stopped: _________

Age at 1st menstrual period: _______ # of pregnancies _____ # live births _____ Age of Menopause: _______

Pain and Fatigue

Do you have any pain? ☐ Yes ☐ No *If yes*, location of pain:_______________________ Intensity (1-10) ______

Pain is: (*Please circle* ONE) Sharp Dull Throbbing Steady Sharp Acute Chronic/Persistent

What do you take for pain relief? ____

Do you have fatigue? ☐Yes☐ No *If yes*, would you describe it as: ☐Mild ☐Moderate ☐Severe ☐Debilitating

Review of Symptoms

Please check all that apply

Constitution:
Appetite
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Unexplained Weight Loss
- ☐ Generalized Weakness
- ☐ Altered Taste
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Hot Flashes
- ☐ None

Immunologic/Infections:
- ☐ Severe allergic reactions
- ☐ Frequent infections
- ☐ Pollen Allergy/Hay fever
- ☐ None

Hematologic/Lymphatic:
- ☐ Easy Bruising
- ☐ Excessive bleeding
- ☐ None

Vision:
- ☐ Glasses/Contacts
- ☐ Blurry Vision
- ☐ Dry Eyes
- ☐ None

Ears, Nose, Mouth, Throat:
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Nosebleeds
- ☐ Sinus Tenderness
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Bleeding gums
- ☐ Mouth sores
- ☐ Dry Mouth
- ☐ None

Cardiovascular:
- ☐ Chest pain
- ☐ Irregular Heartbeat
- ☐ Swelling
- ☐ None

Respiratory/Lung:
- ☐ Shortness of breath
- ☐ Cough
- ☐ Coughing blood
- ☐ Sputum/Phlegm
- ☐ Wheezing
- ☐ None

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Difficulty swallowing
- ☐ Frequent heartburn
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bright blood in stool
- ☐ Dark/tarry stool
- ☐ Change in bowel habits
- ☐ Hemorrhoids
- ☐ None

Genitourinary:
- ☐ Painful urination
- ☐ Excessive nighttime urination
- ☐ Slow starting/stopping
- ☐ Inability to hold urine
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ None

Gynecologic:
- ☐ Abnormal vaginal bleeding
- ☐ Vaginal dryness
- ☐ Vaginal discharge
- ☐ Pelvic Pain
- ☐ None

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

Integumentary/Skin:
- ☐ Rash
- ☐ Itching
- ☐ Sore that won't heal
- ☐ Dry Skin
- ☐ None

Neurological:
- ☐ Headaches
- ☐ Neuropathy
- ☐ Weakness in arms/legs
- ☐ Paralysis
- ☐ Tremors
- ☐ Seizures
- ☐ Poor Coordination
- ☐ Speech impairments
- ☐ Dizziness
- ☐ None

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ I have little interest or pleasure in doing anything.
- ☐ I feel down, depressed, and hopeless
- ☐ Insomnia
- ☐ Memory loss
- ☐ Confusion
- ☐ Hallucinations
- ☐ None

Endocrine:
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive Sweating
- ☐ Increased Thirst
- ☐ None

Breasts:
- ☐ Breast Mass
- ☐ Breast Tenderness
- ☐ Nipple Discharge
- ☐ Skin changes
- ☐ None

Do you have an Advanced Directive, Living Will or Power of Attorney? ☐ Yes ☐ No
(If you indicated yes, please bring documentation with you to your next visit.)

Tobacco Use:

Do you currently use tobacco products? ☐ Yes ☐ No If yes, for how long? ______ yrs
Type: ☐ Cigarettes ☐ Vape ☐ Chew ☐ Cigar ☐ Pipe Pack/Amount used per day: ________________
Have you previously used tobacco products? ☐ Yes ☐ No *If yes*, what year did you quit? ___________

Thank You!!