CHARLESTON CANCER CENTER
Dedicated to Your Tomorrow

PATIENT MEDICAL HISTORY FORM

PATIENT NAME: _____

CHIEF COMPLAINT: **What is the main reason for your visit today?**

_____
_____
_____

Please answer the following questions about your present medical problem as it applies to you.

PAST MEDICAL HISTORY: Please check all that apply:

☐ Cancer
☐ Lymphoma
☐ Leukemia
☐ Blood Problem
☐ Rheumatologic Disease
☐ High Blood Pressure
☐ Thyroid Problems
☐ High Cholesterol
☐ Diabetes
☐ Kidney Disease
☐ Tuberculosis
☐ Asthma
☐ Heart Disease
☐ Arthritis
☐ COPD/Lung Disease
☐ Other _____

PAST SURGICAL HISTORY: Please check all that apply and list date:

☐ Appendectomy (Appendix) _____
☐ Cataract Removal _____
☐ Breast Augmentation _____
☐ Cholecystectomy (Gall bladder) _____
☐ Breast Biopsy _____
☐ Coronary Artery Bypass _____
☐ Breast Mastectomy_____
☐ Hysterectomy Total _____
☐ Hysterectomy Partial_____
☐ Inguinal Hernia_____
☐ Laminectomy _____
☐ Prostatectomy (Prostate) _____
☐ Splenectomy (Spleen) _____
☐ Thyroidectomy _____
☐ Tonsillectomy _____
☐ Colon Surgery_____
☐ Other _____

If you have had cancer, have you ever received chemotherapy or radiation: ____Yes ____No if so, explain:

_____

_____

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MEDICATIONS:
List all medications, or drugs you currently use or have used at home within the last three months. Include those with a prescription from a doctor, those you bought over the counter in a store, any you received from a friend, any vitamins, home remedies, laxatives or any other product you take to improve your health. If you do not know all this information, please bring all the bottles or boxes with you to your next office visit. (Please attach an additional page if you need more space).

Name & Strength of Medication	Amount taken	Approximate date started
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Medication Allergies:
List anything medications you are allergic to:

Item	Describe reaction you had
1.	
2.	
3.	
4.	

FOR WOMEN ONLY
1. Approximately how old were you when you started having menstrual periods? _____
2. Which statement describes you?

- ☐ I am still having regular periods.
- ☐ My periods are irregular.
- ☐ I am pregnant.
- ☐ My periods have stopped on their own (menopause). Age_____
- ☐ I have had an operation which stopped my periods.
  - ☐ One ovary only
  - ☐ Uterus only
  - ☐ Both ovaries
  - ☐ Uterus and one ovary
  - ☐ Other
  - ☐ Uterus and both ovaries

3. Number of pregnancies _____
   Number of children born alive_____
   Number of miscarriages_____
4. Are you or have you ever been on hormone replacement (estrogen/progesterone)? Please explain_____

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The following questions are about your **FAMILY**, you may not know all the information asked. Please answer to the best of your ability.

Please add additional information on the last page.

	LIVING	DECEASED	PRESENT AGE OR AGE AT DEATH	HEATH PROBLEMS	CAUSE OF DEATH IF DECEASED
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____

CHILDREN: **NUMBER OF CHILDREN: _____**

First	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____
Fourth	_____	_____	_____	_____	_____
Fifth	_____	_____	_____	_____	_____

Any history of cancer, leukemia, or lymphoma in your family? If so, give details: _____
_____
_____

SOCIAL HISTORY:

Marital Status Circle One: Single Married Divorced Widowed Partnered

Are you working? _____

What is/was your job position? _____

What are your hobbies? _____

Have you EVER smoked? _____

Do you smoke now? _____

If yes, average number of packs per day? _____

Number of years smoked? _____

Date stopped? _____ Do you desire counseling for smoking cessation? _____

Do you consume alcoholic drinks? _____

If yes, how often? _____

Do you now or have you ever had a problem with alcoholism or drug addiction? _____

If you are of reproductive age, do you desire to address fertility in regard to your diagnosis and treatment options? _____

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Review of Systems: Do you **CURRENTLY** have or are you **NOW** bothered with the following symptoms? Circle Yes or No

Constitutional Symptoms			**Cardiovascular**		
Fever	**Y**	**N**	Heart pain (Angina)	**Y**	**N**
Chills	**Y**	**N**	Irregular heart rhythm	**Y**	**N**
Fatigue/Excessively Tired	**Y**	**N**	Congestive heart failure	**Y**	**N**
Weight Loss	**Y**	**N**	Varicose veins	**Y**	**N**
			Extremity swelling	**Y**	**N**
Allergic/Immunologic			**Gastrointestinal**		
Seasonal allergies	**Y**	**N**	Nausea	**Y**	**N**
Food allergies	**Y**	**N**	Vomiting	**Y**	**N**
IV contrast allergies	**Y**	**N**	Diarrhea	**Y**	**N**
Drug allergies	**Y**	**N**	Constipation	**Y**	**N**
Eyes			Abdominal pain	**Y**	**N**
Excessive tearing	**Y**	**N**	Abdominal swelling	**Y**	**N**
Eye irritation	**Y**	**N**	Loss of appetite	**Y**	**N**
Double vision/Blurred vision	**Y**	**N**	Indigestion/heartburn	**Y**	**N**
			Blood in bowel movement	**Y**	**N**
Ear/Nose/Throat/Mouth			**Genitourinary**		
Hearing difficulty	**Y**	**N**	Blood in urine	**Y**	**N**
Dry mouth	**Y**	**N**	Painful urination	**Y**	**N**
Mouth irritation	**Y**	**N**	Frequent urination	**Y**	**N**
Sore throat/Hoarseness	**Y**	**N**	Hesitation on urination	**Y**	**N**
Difficulty Swallowing	**Y**	**N**	Incontinence	**Y**	**N**
Ear discomfort	**Y**	**N**	Sexual dysfunction	**Y**	**N**
Sinus problem	**Y**	**N**	Genital Mass/tenderness	**Y**	**N**
Ringing in the ears	**Y**	**N**			
Endocrine			**Musculoskeletal**		
Hot flashes	**Y**	**N**	Joint pain	**Y**	**N**
Sweats	**Y**	**N**	Swelling/edema	**Y**	**N**
Heat intolerance	**Y**	**N**	Muscle aches	**Y**	**N**
Cold intolerance	**Y**	**N**	Bone pain	**Y**	**N**
Excessive thirst	**Y**	**N**	Decreased range of motion	**Y**	**N**
Hematological/Lymphatic			**Integumentary**		
Easy bruising	**Y**	**N**	Skin rash	**Y**	**N**
Easy bleeding	**Y**	**N**	Lesions	**Y**	**N**
Tender lymph nodes	**Y**	**N**	Skin breakdown	**Y**	**N**
Swollen lymph nodes	**Y**	**N**	Persistent itch	**Y**	**N**
Breasts			**Neurological**		
Abnormal breast mass	**Y**	**N**	Headaches	**Y**	**N**
Nipple discharge	**Y**	**N**	Dizzy spells	**Y**	**N**
Nipple pain	**Y**	**N**	Numbness/tingling	**Y**	**N**
			Weakness	**Y**	**N**
			Unsteady balance when walking	**Y**	**N**
			Tremor	**Y**	**N**
Respiratory			**Psychological**		
Wheezing	**Y**	**N**	Are you generally satisfied with your life?	**Y**	**N**
Persistent cough	**Y**	**N**	Do you feel nervous or anxious?	**Y**	**N**
Sputum production	**Y**	**N**	Do you have trouble sleeping?	**Y**	**N**
Shortness of breath	**Y**	**N**	Do you have periods of extreme sadness or crying?	**Y**	**N**
Chest pain on breathing	**Y**	**N**			
Coughing up blood	**Y**	**N**			

The above is true and correct to the best of my knowledge.

Patient Signature: _____

Physician Signature: _____

Date: _____/_____/_____