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FLORIDA CANCER AFFILIATES
The US Oncology Network
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PATIENT HISTORY

Patient Name _____

CONFIDENTIAL OFFICE USE ONLY

Date: __ / __ /____

Referring Physician: _____

Name: _____ _____ _____
Last First Middle

Family Physician: _____

Date of Birth: __ /__ /____ **Age:**_____ **Phone:** ___ - ___ - ____

Please answer all questions below. If you are unable to answer any question, please circle it and call it to the attention of the examing doctor.

HISTORY OF PRESENT ILLNESS:

What problem brings you to this office? _____

Do you have a history of :

Blood Disease	☐ YES ☐ NO	**When?**	
Cancer	☐ YES ☐ NO	**When?**	
Other	☐ YES ☐ NO	**When?**	

If yes, what type? _____

Prior Treatment:

Chemotherapy / Drug	☐ YES ☐ NO	When?	
Radiation	☐ YES ☐ NO	When?	
Surgery	☐ YES ☐ NO	When?	
Other	☐ YES ☐ NO	When?	

X-Ray Treatment of:

Skin	☐YES ☐ NO	When?	
Thyroid	☐YES ☐ NO	When?	
Tonsils	☐YES ☐ NO	When?	

MEDICATIONS: List all medications you take (prescription and over the counter)

Medication	Dosage	Times Per Day	How long have you taken the medication

Have you ever been told to take antibiotics before or after dental procedures? ☐ YES ☐ NO

Do you have any drug allergies or allergies? ☐ YES ☐ NO **Allergic to what?** _____

If yes, what type of reaction? _____

PRIOR BLOOD TRANSFUSIONS: ☐ YES ☐ NO When? _____

VACCINATIONS RECEIVED:

Flu ☐ YES ☐ NO When?_____ **Hepatitis** ☐YES ☐NO When? _____

Pneumovax ☐ YES ☐ NO When?_____

OTHER MEDICAL PROBLEMS (Diabetes, Hypertension etc.)

Date	Doctor	Diagnosis

Please List all hospitalizations and surgeries (if none, PLEASE write "none").

Year	Duration	Reason / Result	Hospital / Physician

Additional Information

Any recommended surgical operations which you have not undergone? ☐ YES ☐ NO

If yes, describe:_____

OCCUPATIONAL EXPOSURE

Have you had exposure to:	YES	NO	WHEN		YES	NO	WHEN
Asbestos				Agent Orange			
Toxic Metals or Radioactive Material				Worked in a Mine			
Vinyl Chloride or Toxic Chemicals				Lived on a Farm			

SOCIAL HISTORY

Marital Status ☐ S ☐M ☐D ☐ W **Current Occupation:** _____

If retired, last employment: _____

Do you smoke cigarettes? ☐ YES ☐ NO **Have you ever smoked cigarettes?** ☐ YES ☐ NO

If yes, how many packs per day? _____ **for how many years?**_____ **When did you quit?**_____

Do you drink alcohol? ☐ YES ☐ NO If yes, average daily consumption?_____ for_____ years.

Education (circle last year completed)

GRADE SCHOOL: 7 8 9 10 11 12 **COLLEGE:** 1 2 3 4 **POST GRADUATE**

Do you live alone? ☐ YES ☐ NO If not, with whom?_____

Who can you depend on?_____

Do you drive? ☐ YES ☐ NO

Do you have a Living Will? ☐ YES ☐ NO

Patient Name _____, _____

FAMILY HISTORY

	YES	NO	Family Member		YES	NO	Family Member
Diabetes	☐	☐		Tuberculosis	☐	☐	
Heart Disease	☐	☐		Cancer	☐	☐	
Strokes	☐	☐		Melanoma	☐	☐	
Anemia	☐	☐		Bleeding Tendency	☐	☐	
Kidney Disease	☐	☐					

Additional Information

FAMILY MEDICAL STATUS

Present age or age at death	Living	Dead	Medical problems or cause of death	Present age or age at death	Living	Dead	Medical problems or cause of death
Father Age_____	☐	☐		Mother Age_____	☐	☐	
Brother Age_____	☐	☐		Sister Age_____	☐	☐	
	☐	☐			☐	☐	
	☐	☐			☐	☐	
	☐	☐			☐	☐	

Significant illness in children: _____

Additional Information

REVIEW OF SYSTEMS

CONSTITUTIONAL

Symptoms	YES	NO	When
Weight Loss _____lbs	☐	☐	
Weight Gain _____lbs	☐	☐	
Chills or Fever	☐	☐	
Fatigue	☐	☐	
Night Sweats	☐	☐	
Are you up most of the day?	☐	☐	
In bed more than half the time?	☐	☐	

☐ Left Handed ☐ Right Handed

EYES, EARS, NOSE, THROAT, MOUTH

SYMPTOMS	YES	NO	When
Eye Surgery Cataracts	☐	☐	
Glaucoma	☐	☐	
Vision Change	☐	☐	
Double Vision	☐	☐	
Hearing Loss	☐	☐	
Ear Aches	☐	☐	
Difficulty Swallowing	☐	☐	
Sinus Infections	☐	☐	
Sore Throats	☐	☐	

NEUROLOGIC

Symptoms	YES	NO	When
Pain, if yes see below	☐	☐	
Where / Intensity /Duration:			
Headaches	☐	☐	
Insomnia	☐	☐	
Seizures-Epilepsy	☐	☐	
Memory Defect	☐	☐	
Balance Problems	☐	☐	
Difficulty Walking in the Dark	☐	☐	
Numbness & Tingling Extremities	☐	☐	
Shaking or Tremor of Hands	☐	☐	

Additional symptoms:

Patient Name _____, _____ ___

CARDIOVASCULAR

Have you had:	YES	NO	When		YES	NO	When
Shortness of Breath with Exercise	☐	☐		Rheumatic Fever	☐	☐	
Ankle Swelling	☐	☐		Stroke or Paralysis	☐	☐	
High Blood Pressure	☐	☐		Circulation Problems	☐	☐	
Rapid Heart Beat	☐	☐		Heart Attack	☐	☐	
Dizziness	☐	☐		Heart Murmur	☐	☐	
Fainting Spells	☐	☐		Heart Valve Problem	☐	☐	
Chest Pain or Pressure-Angina	☐	☐		Heart Infection	☐	☐	
Leg Cramps	☐	☐		Sleep on_____pillows	☐	☐	

Additional Information

RESPIRATORY

Have you had:	YES	NO	When		YES	NO	When
Tuberculosis	☐	☐		Emphysema	☐	☐	
Coughed up Blood	☐	☐		Shortness of Breath at Night	☐	☐	
Asthma or Wheezing	☐	☐		Pleurisy	☐	☐	
Bronchitis	☐	☐		Pneumonia	☐	☐	
Sputum Production	☐	☐		Blood Clot in Lung	☐	☐	

Additional Information

GASTROINTESTINAL

Have you had:	YES	NO	When		YES	NO	When
Increased Appetite	☐	☐		Abdominal Swelling	☐	☐	
Decreased Appetite	☐	☐		Change in Bowel Movement	☐	☐	
Nausea and Vomiting	☐	☐		Constipation	☐	☐	
Abdominal Pain or Cramps	☐	☐		Diarrhea	☐	☐	
Ulcer Disease	☐	☐		Blood in Bowel Movement	☐	☐	
Yellow Jaundice-Hepatitis	☐	☐		Black Bowel Movement	☐	☐	
Liver Disease-Cirrhosis	☐	☐		Diverticulitis	☐	☐	
Gall Bladder Problem - Gallstone	☐	☐		Colitis	☐	☐	
Pancreatic Disease	☐	☐		Hemorrhoids	☐	☐	

Additional Information

Patient Name _____, _____ ___

GENITOURINARY

Have you had:	YES	NO	When		YES	NO	When
Frequent Urination	☐	☐		Urinate during the night How many times_____	☐	☐	
Painful Urination	☐	☐					
Blood in Urine	☐	☐		Pain in Testicles (men)	☐	☐	
Cystitis	☐	☐		Prostate Problems (men)	☐	☐	
Incontinence	☐	☐		Loss of Sexual Potency (men)	☐	☐	
Kidney Stone	☐	☐		Swelling of Breast (men)	☐	☐	
Hernia	☐	☐		Hard to Start Urine (men)	☐	☐	
Bloody or Other Discharge	☐	☐		Testicular Mass (men)	☐	☐	
Venereal Disease	☐	☐		Decreased Urine Flow (men)	☐	☐	

Additional Information

MUSCULOSKELETAL

Have you had:	YES	NO	When		YES	NO	When
Arthritis-Type	☐	☐		Osteoporosis	☐	☐	
Muscle Pain or Cramps	☐	☐		Joint Replacement	☐	☐	
Painful or Swollen Joints	☐	☐		History of Fracture	☐	☐	
Lupus	☐	☐		Loss of Limb	☐	☐	
Gout	☐	☐		Bone Disease	☐	☐	
Backaches	☐	☐		Laminectomy-Disc Disease	☐	☐	

Additional Information

ENDOCRINE

Have you had:	YES	NO	When
Thyroid Disease	☐	☐	
Heat Intolerance	☐	☐	
Bleeding after Tooth Extraction	☐	☐	
Diabetes	☐	☐	
Adrenal Disease	☐	☐	
Hair Loss or Gain	☐	☐	
Voice Change	☐	☐	
Salt Loss or Water Retention	☐	☐	

HEMATOLOGY

Have you had:	YES	NO	When
Tendency to Bleed or Bruise Easily	☐	☐	
Lymph Node Enlargement	☐	☐	
Frequent Nose Bleed	☐	☐	
Bleeding after Tooth Extraction	☐	☐	
White Blood Cell Problem	☐	☐	
Platelet Problem	☐	☐	
Anemia	☐	☐	
History of Leukemia	☐	☐	
Abnormal Spleen	☐	☐	
Blood Clots; Treatment	☐	☐	

Additional Information

Patient Name _____, _____ ___

FEMALE

Have you had:	YES	NO	When
History of Menstrual Irregularity	☐	☐	
Vaginal Bleeding Currently	☐	☐	
Use of Hormones during Menopause	☐	☐	
Breast Fed Infant	☐	☐	
Age at Menopause	☐	☐	
Age of first Menses (Period)	☐	☐	
Number of times Pregnant	☐	☐	
Number of Live Births	☐	☐	
Age at first Delivery	☐	☐	
Means of Birth Control	☐	☐	
Last Menstrual Period	☐	☐	
Last Mammogram	☐	☐	
Last Pap Smear	☐	☐	

Have you had:	YES	NO	When
Breast Discharge	☐	☐	
Breast Swelling	☐	☐	
Breast Pain	☐	☐	
Breast Mass	☐	☐	
Breast Biopsy	☐	☐	
Abnormal Mammogram	☐	☐	
Vaginal Discharge	☐	☐	
Pelvic Pain	☐	☐	
D&C	☐	☐	
Hysterectomy	☐	☐	
Removal of Ovaries	☐	☐	

Additional Information

INTEGUMENTARY (Skin)

Have you had:	YES	NO	When
Red / Blot Areas	☐	☐	
Dark Moles	☐	☐	
Rash / Itching	☐	☐	

PSYCHIATRIC

Have you had:	YES	NO	When
Depression	☐	☐	
Mood Swings	☐	☐	

Additional Information

Notes

Did someone other than patient complete this form? ☐ Yes ☐ No

If yes, your relationship to patient: _____

Patient Signature: _____ Date: _____

Would you like a copy of this questionnaire? ☐ Yes ☐ No