Virginia Cancer Care

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Medical History Form

NAME: _____ DOB: _____

Sex: O **MALE** O **FEMALE**

Reason for visit: _____

Referring Physician: _____ Phone: _____ Fax: _____
Primary Care Doctor: _____ Phone: _____ Fax: _____
Pharmacy: _____ Address: _____ Phone: _____

Please indicate if you have any <u>current</u> symptoms in any of the following areas:

- **General tiredness, weight loss, decreased appetite, etc**
- **Fevers**
- **Eyes (Blurred vision, changes in vision)**
- **Skin (Lumps, ulcers, changing or bleeding moles)**
- **Ears, Mouth, Throat (decreased hearing, soreness or swallowing issues)**
- **Stomach (pain, indigestion, diarrhea, nausea or vomiting)**
- **Lungs (difficulty breathing- at rest or w/normal exertion)**
- **Heart/Circulation (chest pain or swollen ankles)**
- **Neurological (seizures, hand or foot numbness/weakness)**
- **Bleeding or easy bruising (if so, where_____)**
- **Reproductive/Urinary (prostate or breast exam)**
- **Thyroid/Endocrine (excessive thirst, sweating)**
- **Psychiatric (guilt, lack of hope, change in sleep, unable to enjoy pleasure)**
- **Lymph (enlarged lymph nodes)**
- **Muscles/Joints/Bones (pain, aches arthritis)**
- **Other (_____)**

<u>Chronic Medical Problems:</u>

_____
_____
_____
_____
_____

<u>Previous Surgeries and Hospitalizations (include dates):</u>

_____
_____
_____
_____

Last Mammogram date: _____ Results: _____
Last colonoscopy date: _____ Results: _____

Medications currently taking (or provide a copy of medication list):

Name of Medication	Dose	Frequency	Prescribing Doctor

Allergies to Medications: _____ Type of Reaction: _____
Are you allergic to latex? O **Yes** O **No**
Are you allergic to iodine/IV contrast? O **Yes** O **No**
Have you ever had a blood transfusion? O **Yes** O **No** **Any reactions?** O **Yes** O **No**

Have you had the influenza (flu) vaccine? O **Yes** O **No**
Have you had the pneumonia vaccine? O **Yes** O **No**

Social History:

Marital Status (circle): SINGLE MARRIED DIVORCED WIDOWED
Lives With: _____

Employment Status (circle): Full-time Part-time Retired
Occupation: _____ Job duties: _____

Do you smoke, or previous smoker? O **Yes** O **No** **If YES, for how long: _____**
Packs per day: _____ Quit date: _____
Do you drink alcohol? O **Yes** O **No**
If yes, how many drinks per Day: _____ Week: _____ Month: _____
Do you do any illicit drugs? O **Yes** O **No** **If yes, what kind? _____**

Family History:

Mother (age, health): _____
Father (age, health): _____
Sisters (age, health): _____
Brothers (age, health): _____
Children (age, health): _____

Family History of:

Heart Disease	O **Yes** O **No**	**Strokes**	O **Yes** O **No**
High Blood Pressure	O **Yes** O **No**	**Diabetes**	O **Yes** O **No**
Blood clots	O **Yes** O **No**	**Bleeding disorders**	O **Yes** O **No**

Do you have a family history of Cancer? O **Yes** O **No**
If YES, who and what type of Cancer?

_____
_____
_____

Gynecological History (for women):

Age of Menarche: _____ Age of Menopause: _____
Oral Contraceptive Pills: Current Use? O **Yes** O **No** **Past Use?** O **Yes** O **No**
Hormone Replacement Therapy: Current Use? O **Yes** O **No** **Past Use?** O **Yes** O **No**

Number of pregnancies: _____ If currently pregnant, how many weeks: _____
Number of Live Births: _____ Miscarriages: _____ Still Births: _____

For Medical Staff Use Only:

Vital Signs:

Height: _____ Weight: _____ Temp: _____
BP: _____ arm: L R Pulse: _____ Respirations: _____

Encounter notes:

_____
_____
_____
_____
_____
_____
_____
_____

Labs: _____

Diagnostics: _____

Follow-up: _____

Time spent with patient: _____