

Name: \_\_\_\_\_

Date: \_\_\_\_\_

PID #: \_\_\_\_\_ (office use only)



Southwest Hematology Oncology, P.C.

# PATIENT HISTORY FORM

Reason for consultation: \_\_\_\_\_

## PAST MEDICAL HISTORY *Please check if you have been diagnosed with any of the following conditions.*

<input type="checkbox"/> Asthma	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Stomach ulcer
<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Triglycerides	<input type="checkbox"/> Lupus	<input type="checkbox"/> GERD (reflux)
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Stroke	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Hiatal Hernia
<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Diverticulosis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Underactive Thyroid	<input type="checkbox"/> Migraines	<input type="checkbox"/> Colon Polyps
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Overactive Thyroid	<input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> Enlarged Prostate
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Depression
<input type="checkbox"/> Irregular Heart Rhythm	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Cancer _____

Are there any other medical conditions that you have? \_\_\_\_\_

## PAST SURGICAL HISTORY *Please check if you have had any of the following surgical procedures and write the year that you had the procedure in the box.*

<input type="checkbox"/> Hysterectomy (removal of uterus)	<input type="checkbox"/> Tonsillectomy (removal of tonsils)	<input type="checkbox"/> C-section	
<input type="checkbox"/> Salpingo-oophorectomy (removal of ovaries and tubes)	<input type="checkbox"/> Adenoidectomy (removal of adenoids)	<input type="checkbox"/> D & C	
<input type="checkbox"/> Mastectomy (removal of breast)	<input type="checkbox"/> Appendectomy (removal of appendix)	<input type="checkbox"/> Tubal ligation	
<input type="checkbox"/> Lumpectomy (removal of breast lump)	<input type="checkbox"/> Cholecystectomy (removal of gallbladder)	<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Prostatectomy (removal of prostate)	<input type="checkbox"/> CABG (heart bypass surgery)	<input type="checkbox"/> Hip replacement	
<input type="checkbox"/> Colon Resection (partial removal of colon)	<input type="checkbox"/> Coronary artery stent placement (in heart)	<input type="checkbox"/> Knee replacement	
<input type="checkbox"/> Liver Resection (removal of a section of liver)	<input type="checkbox"/> Heart valve replacement	<input type="checkbox"/> Gastric Bypass	
<input type="checkbox"/> Lobectomy (partial removal of lung)	<input type="checkbox"/> TURBT (resection of a bladder tumor)	<input type="checkbox"/> Gastrectomy (removal of stomach)	
<input type="checkbox"/> Pneumonectomy (removal of one lung)	<input type="checkbox"/> TURP (resection of part of prostate)	<input type="checkbox"/> Partial Gastrectomy (partial removal of stomach)	
<input type="checkbox"/> Splenectomy (removal of spleen)	<input type="checkbox"/> Thyroidectomy (removal of thyroid)	<input type="checkbox"/> Whipple Resection (removal of head of pancreas)	

Are there any other surgeries that you have had? \_\_\_\_\_

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## SOCIAL HISTORY

Marital Status:  Single  Married  Divorced  Widowed

Occupation: \_\_\_\_\_

Religious preference: \_\_\_\_\_

Have you ever used tobacco?  Yes  No  Current use  Past use [Quit \_\_\_\_\_ years ago]

If so, which type(s)?  Cigarettes  Cigars  Pipes  Chewing tobacco

How much use per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Do you consume alcohol?  Yes  No

If so, indicate which types:  Beer  Wine  Other \_\_\_\_\_

Quantity \_\_\_\_\_ How often?  Daily  Weekly  Socially

Do you use any recreational drugs?  Yes  No

## REPRODUCTIVE HISTORY (for female patients only)

Age of first period \_\_\_\_\_ Number of pregnancies \_\_\_\_\_ Number of births \_\_\_\_\_ Age of 1<sup>st</sup> birth \_\_\_\_\_

Have you gone through menopause?  Yes  No If yes, at what age? \_\_\_\_\_

Have you ever taken oral contraceptive pills?  Yes  No

If so, how many years \_\_\_\_\_ and from what age \_\_\_\_\_ to what age \_\_\_\_\_?

Have you ever taken hormone replacement therapy?  Yes  No

If so, for how many years \_\_\_\_\_, and from what age \_\_\_\_\_ to what age \_\_\_\_\_?

Have you ever taken any medications for the treatment of infertility?  Yes  No

Have you ever had a breast biopsy before?  Yes  No

If so, how many breast biopsies have you had? \_\_\_\_\_

Did any the biopsies show Atypical Ductal or Lobular Hyperplasia?  Yes  No

## FAMILY HISTORY *Please indicate any medical problems (including cancer and age at diagnosis) for your relatives.*

Mother	Maternal grandma	Maternal grandpa
Father	Paternal grandma	Paternal grandpa
Brother (s)		
Sister (s)		
Son (s)		
Daughter (s)		
Maternal aunt (s)		
Maternal uncle (s)		
Paternal aunt (s)		
Paternal uncle (s)		
Other		
Other		
Other		



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**SYSTEM REVIEW** Please check if you are experiencing any of the following symptoms and sign below.

**GENERAL:**

- Yes  No.....Fatigue
- Yes  No.....Generalized weakness
- Yes  No.....Fever
- Yes  No.....Chills
- Yes  No.....Night sweats
- Yes  No.....Trouble sleeping
- Yes  No.....Unintentional weight loss
- Yes  No.....Significant weight gain

**SKIN:**

- Yes  No.....Rashes
- Yes  No.....Lesions
- Yes  No.....Sores
- Yes  No.....Bruising
- Yes  No.....Itching
- Yes  No.....Nail changes

**HEAD:**

- Yes  No.....Vision changes
- Yes  No.....Hearing loss
- Yes  No.....Ringing in ears
- Yes  No.....Nose bleeds
- Yes  No.....Dry mouth
- Yes  No.....Hoarseness
- Yes  No.....Frequent sore throats

**HEART/CIRCULATON:**

- Yes  No.....Heart palpitations
- Yes  No.....Pain in legs when walking
- Yes  No.....Shortness of breath when lying flat
- Yes  No.....Swollen ankles

**LUNGS:**

- Yes  No.....Shortness of breath
- Yes  No.....Cough
- Yes  No.....Sputum/mucus production
- Yes  No.....Coughing up blood
- Yes  No.....Wheezing

**BREASTS:**

- Yes  No.....Lumps/masses
- Yes  No.....Nipple discharge
- Yes  No.....Pain
- Yes  No.....Skin changes

**ENDOCRINE:**

- Yes  No.....Heat intolerance
- Yes  No.....Cold intolerance
- Yes  No.....Excessive thirst
- Yes  No.....Excessive hunger
- Yes  No.....Hot flashes
- Yes  No.....Excessive sweating

**GASTROINTESTINAL:**

- Yes  No.....Mouth sores
- Yes  No.....Heartburn
- Yes  No.....Difficulty swallowing
- Yes  No.....Painful swallowing
- Yes  No.....Poor appetite
- Yes  No.....Nausea
- Yes  No.....Vomiting
- Yes  No.....Constipation
- Yes  No.....Diarrhea
- Yes  No.....Feeling full quickly when eating
- Yes  No.....Abdominal bloating
- Yes  No.....Abdominal pain
- Yes  No.....Rectal bleeding
- Yes  No.....Black tarry stools

**KIDNEYS/BLADDER**

- Yes  No.....Pain when urinating
- Yes  No.....Frequency of urination
- Yes  No.....Urgency of urination
- Yes  No.....Hesitancy of urination
- Yes  No.....Getting up at night to urinate
- Yes  No.....Blood in urine
- Yes  No.....Incontinence
- Yes  No.....Pain in kidneys

**MUSCULOSKELETAL:**

- Yes  No.....Joint pain
- Yes  No.....Muscle pain
- Yes  No.....Back pain
- Yes  No.....Bone pain

**NEUROLOGIC:**

- Yes  No.....Headaches
- Yes  No.....Dizziness
- Yes  No.....Weakness in extremities
- Yes  No.....Numbness/tingling in extremities
- Yes  No.....Fainting
- Yes  No.....Seizures
- Yes  No.....Tremors

**PSYCHOLOGIC:**

- Yes  No.....Depression
- Yes  No.....Anxiety
- Yes  No.....Nervousness
- Yes  No.....Memory changes

**HEMATOLOGIC/LYMPHATIC:**

- Yes  No.....Swollen lymph nodes
- Yes  No.....Painful lymph nodes

*By signing below I declare that I have completed this form in its entirety.*