Patient History Form

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____

Cell Phone: _____ Work Phone: _____

Emergency Contact & Phone: _____

Providers

Referring physician:	Medical Oncologist:
Primary Care Physician:	Other Provider:
Other Provider:	Other Provider:

Medications

Medications	Dose	Times per Day

If you need to list more medications, please write them on an additional sheet of paper

Allergies ☐ *No Allergies*

Allergy	Allergic Reaction
Allergy to Medications? ☐ Y ☐ N Explain:	
Allergy to IV Contrast? ☐ Y ☐ N Explain:	

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Medical History

Check all that apply					
Brain/Cognitive/Psychologic		**Lung/Respiratory**		**Bladder/Kidney/Urologic**	
☐	Stroke	☐	Asthma	☐	Stones ☐Bladder ☐Kidney
☐	Seizures/Epilepsy	☐	Bronchitis	☐	Kidney Disease
☐	Migraines/Headaches	☐	Emphysema	**Muscular/Skeletal**	
☐	Alzheimer's/Dementia	☐	Lung Disease	☐	Arthritis ☐Osteo ☐Rheumatoid
☐	☐Depression ☐Anxiety ☐Bipolar ☐Suicidal	☐	Chronic Sinus Headaches	☐	Muscle Weakness/Pain
☐	Sleep Disorders	**Heart/Cardiac**		☐	Osteoporosis
☐	Autism	☐	High Cholesterol	☐	Bone Fractures
☐	Alcoholism/Drug Abuse	☐	Heart Disease	**Miscellaneous**	
Stomach/Intestinal/Digestive		☐	High Triglycerides	☐	Chronic Fatigue Syndrome
☐	Diabetes Type: _____	☐	Arrythmia	☐	Parathyroid Disease
☐	Ulcerative Colitis/Crohn's Disease	**Blood/Hepatic/Circulation**		☐	Lactating
☐	Gastroesophageal Reflux Disease/Acid Reflux	☐	Jaundice	☐	Infertility
☐	☐Under ☐Over Weight	☐	Bruise Easily	☐	Herpes
☐	Bowel Disorder	☐	Anemia	☐	Bleeding Gums
☐	Constipation	☐	Hemochromatosis	☐	Dentures
☐	Diarrhea	☐	Gall Bladder Disease/Stones	☐	Gout
☐	Hypoglycemia	☐	HIV/AIDS	☐	Fibromyalgia
☐	Eating Disorder ☐ Anorexia ☐Bulimia ☐Binge Eating	☐	Hepatitis Type:_____	**Other:_____**	
		☐	Liver Disease	**Other:_____**	

Patient Name: _____

Prior history of cancer? ☐ Y ☐ N Explain:
Prior radiation therapy treatment? ☐ Y ☐ N Explain:
Prior chemotherapy? ☐ Y ☐ N Explain:
Are you pregnant, or still want to have children? ☐ Y ☐ N
Do you have a pacemaker or defibrillator? ☐ Y ☐ N Explain:
If you have been diagnosed with head or neck cancer, who is your dentist?

Surgeries or Recent Hospitalizations

Type/Reason	Date (MM/YY)	Location/Facility

Family Cancer History

Relatives with History of Cancer (Relationship)	Cancer Type	Age at Diagnosis

Social History

Occupation:	☐ Retired ☐ Unemployed ☐ L.O.A. ☐ Disabled
Employer:	Years of Education/Highest Degree:
Exposure to Hazardous Materials? ☐ Y ☐ N Explain:	
Do you drink alcohol? ☐ Y ☐ N Number of drinks per day:	
Smoke Cigarettes? ☐ Y ☐ N	Type: _____ Packs/day: _____ # of Years: _____
	Age at start: _____ Age at stop: _____
Other Tobacco (check all that apply): ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew	
Do you have concerns about: ☐ Transportation ☐ Finances ☐ Other_____	

Current Symptoms

Check all that apply							
☐	Fever	☐	Visual Changes	☐	Swollen Lymph Node	☐	Bloody Stools
☐	Chills	☐	Double Vision	☐	Masses	☐	Hemorrhoids
☐	Weight Loss	☐	Ear Pain	☐	Chest Pain	☐	Urinary frequency
☐	Fatigue	☐	Ringing	☐	Shortness of Breath	☐	Burning
☐	Headaches	☐	Hoarseness	☐	Heartburn	☐	Bleeding
☐	Numbness	☐	Difficulty Swallowing	☐	Nausea	☐	Leg Swelling
☐	Seizures	☐	Cough	☐	Diarrhea	☐	Muscle Weakness
☐	*Other:*			☐	*Other:*		
Pain: Are you in Pain? ☐ Y ☐ N		Scale of 1 – 10:		Medications for Pain:			

Other important information: _____

(Please detail any other important information on an additional sheet of paper)