HIGHLANDS ONCOLOGY GROUP

Highlands Oncology
Patient History

Name (First and Last) _____ Today's Date: _____

Date of Birth: _____ Referring Physician: _____

☐ Male ☐ Female Primary Care Physician: _____

OB/Gyn Physician: _____

Other Physicians: _____

Reason for Today's Visit: _____

_____

Personal Medical History: Please check all that apply and include date of diagnosis

☐	Anemia	
☐	Arthritis	
☐	Asthma	
☐	Blood Disorder/Coagulopathy	
☐	Cancer (please list type)	
	1.	
	2.	
	3.	
☐	Diabetes	
☐	Emphysema/COPD	
☐	Epilepsy	
☐	Exposure to Asbestos	
☐	Heart Disease (e.g. Heart Attack)	
☐	Hepatitis Type: _____	

☐	High Blood Pressure	
☐	Kidney Disease	
☐	Liver Disease	
☐	Mental Illness	
☐	Pneumonia	
☐	Sexually Transmitted Disease	
☐	Sleep Apnea	
☐	Stroke	
☐	Thyroid Disease	
☐	Tuberculosis	
☐	Ulcer	
☐		
☐		
☐		

Hospitalizations/Surgeries: Please list all hospitalizations and surgeries

	Date	Reason for Hospitalization or Type of Surgery	Where	Doctor
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Previous Treatment for Cancer (if applicable) When, Where

Radiation Therapy: _____

Chemotherapy: _____

Hormone Therapy: _____

Highlands Oncology Group Patient History

Name (First and Last) _____ Date of Birth _____

Immunizations: Please check previous immunizations received and include date of last vaccine if known.

Flu ☐	Hepatitis B ☐
Shingles ☐	Pneumonia ☐

Medications: Please list current prescriptions and over-the-counter medications, as well as herbals, supplements and vitamins.

	Medication	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

Pharmacy Name and location _____

Allergies

Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list the medications that you are allergic to and the type of reaction:

_____
_____
_____
_____

Are you allergic to:

Contrast/IV dye for scans ☐ Yes ☐ No
Latex: ☐ Yes ☐ No
Tape: ☐ Yes ☐ No
Vaccines: ☐ Yes ☐ No If yes, please list the type of vaccine: _____
Other allergies: ☐ Yes ☐ No
If yes, please list other allergies: _____

Blood Transfusions

Have you ever had a blood transfusion? ☐ Yes ☐ No Reason: _____
If yes, did you have a reaction? ☐ Yes ☐ No
Date of last blood transfusion: _____

Highlands Oncology Group Patient History

Name (First and Last) _____ Date of Birth _____

Screenings

	Date	
Last mammogram (female)		
Last PAP smear (female)		
Last colonoscopy or sigmoidoscopy		
Last bone density scan		
Other		

Social History

Marital Status: ❑ Single ❑ Married ❑ Domestic partner ❑ Divorced ❑ Widowed

Do you have children? ❑ Yes ❑ No If yes, how many children: _____

Occupation (previous if retired): _____ ❑ Retired

Have you served in the military? ❑ Yes ❑ No If yes, dates of service _____

Do you have an Advance Directive, Living Will Power of Attorney? ❑ Yes ❑ No

If you have one of these, please bring to your next appointment

Do you currently use tobacco products:

❑ Yes Use per day: ❑ Cigarettes: _____ ❑ Cigars: _____ ❑ Pipe: _____ ❑ Chewing tobacco: _____

For how many years have you used the above tobacco product?

❑ No Have you ever used tobacco products in the past? ❑ Yes ❑ No

If yes, use per day: ❑ Cigarettes: _____ ❑ Cigars: _____ ❑ Pipe: _____ ❑ Chewing tobacco: _____

When did you quit? _____ For how many years did you use the above tobacco product? _____

How many servings of wine, beer or other alcoholic beverage(s) do you drink per day? _____ Per week? _____

Do you have a history of alcoholism? ❑ Yes ❑ No

Have you used illegal drugs? ❑ Yes ❑ No

If yes, which ones? _____

Do you use marijuana? ❑ Yes ❑ No

What do you do for exercise? _____ How many times per week? _____

Family History: Please include age at diagnosis

	Grandfathers		Grandmothers		Parents		Siblings		Children	
	Paternal	Maternal	Paternal	Maternal	Father	Mother	Brother	Sister	Son	Daughter
Cancer:										
Breast										
Colon/Rectal										
Lung										
Melanoma										
Ovarian										
Pancreatic										
Prostate										
Stomach/Gastric										
Uterine/Endometrial										
Other:										

Highlands Oncology Group Patient History

Name (First and Last) _____ Date of Birth _____

Symptoms: Please check all that apply or *None*

Do you have pain? ☐ Yes ☐ No
if yes, where? _____ Intensity (1-10) _____ Freqency: _____

General:
- ☐ Change in appetite
- ☐ Weight loss
- ☐ Fatigue
- ☐ Generalized weakness
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Hot flashes
- ☐ None

Eyes:
- ☐ Glasses/contacts
- ☐ Blurred vision
- ☐ Double vision
- ☐ Dry eyes
- ☐ None

Ears, nose, mouth, throat:
- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Sinus trouble
- ☐ Dental problems
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Bleeding gums
- ☐ None

Heart
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swollen feet , ankle or hands
- ☐ None

Lungs:
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Sputum or phlegm production
- ☐ None

Digestive:
- ☐ Difficulty swallowing
- ☐ Frequent heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stools
- ☐ Change in bowel habits
- ☐ Hemorrhoids
- ☐ Abdominal pain
- ☐ None

Genitourinary:
- ☐ Pain/burning with urination
- ☐ Excessive nighttime urination
- ☐ Excessive daytime urination
- ☐ Slow starting or stopping
- ☐ Unable to hold urine
- ☐ Blood in the urine
- ☐ None

Men only...
- ☐ Prostate infections
- ☐ Impotence

Women only...
- ☐ Vaginal Discharge or bleeding
- ☐ Painful intercourse

Gynecologic/Breast
- ☐ Breast tenderness
- ☐ Beast masses
- ☐ Breast skin changes
- ☐ Nipple discharge
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Vaginal bleeding
- ☐ Pelvic pain

Bones, joints, muscles:
- ☐ Cramping
- ☐ Joint pain
- ☐ Swollen joints
- ☐ Bone pain
- ☐ Muscle pain
- ☐ Back pain
- ☐ None

Endocrine:
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive sweating
- ☐ Increased thirst
- ☐ None

Nervous system:
- ☐ Headaches
- ☐ Dizziness or vertigo
- ☐ Fainting
- ☐ Seizures
- ☐ Poor coordination
- ☐ Weakness of arms or legs
- ☐ Numbness in arms or legs
- ☐ None

Immunologic:
- ☐ Severe allergic reactions
- ☐ Frequent or severe infections
- ☐ Pollen allergies/hay fever
- ☐ None

Skin:
- ☐ Rash, hives or itching
- ☐ Dry skin
- ☐ A sore that won't heal
- ☐ None

Blood Disorders:
- ☐ Easy bruising
- ☐ Abnormal bleeding
- ☐ Enlarged lymph nodes
- ☐ None

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Trouble sleeping/insomnia
- ☐ Confusion
- ☐ Memory loss
- ☐ None