Tallahassee Cancer Institute

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Reason For This Visit:_____

_____

Medical History: (Check the items that apply to you, currently or in the past)

None	☐	Asthma	☐	Lupus-Autoimmune	☐
Anemia	☐	Chronic Lung (COPD)	☐	Reynaud's Syndrome	☐
Bleeding Disorder	☐	Pneumonia/Bronchitis	☐	Rheumatoid Arthritis	☐
Blood Clots	☐	TB (Tuberculosis)	☐	Osteoarthritis	☐
Blood Disorder	☐	Sleep Apnea	☐	Chronic back pain	☐
Frequent infections	☐	Colon Polyps	☐	Osteoporosis	☐
HIV / AIDS	☐	Crohn's Disease	☐	Fracture	☐
Diabetes	☐	Diverticulitis	☐	Stroke	☐
Thyroid Disease	☐	Irritable Bowel Syndrome	☐	Neuropathy	☐
High Blood Pressure	☐	Ulcerative Colitis	☐	Parkinson's Disease	☐
High Cholesterol	☐	Stomach Ulcers	☐	Paralysis	☐
Atrial Fibrillation	☐	GERD/Heartburn	☐	Seizures	☐
Congestive Heart Failure	☐	Hiatal Hernia	☐	Migraines	☐
Heart Attack-MI	☐	Gallstones	☐	Shingles	☐
Heart Disease	☐	Cirrhosis of Liver	☐	Glaucoma / Cataracts	☐
Rheumatic Fever	☐	Hepatitis A/ B/ C	☐	Hearing loss	☐
Heartburn / Reflux	☐	Pancreatitis	☐	Cancer	☐
Heart Murmur	☐	Kidney Stone	☐	Leukemia	☐
Irregular Heart Beat	☐	Kidney Disease/Failure	☐	Lymphoma	☐
Peripheral Vascular Disease	☐	Freq. Urinary Tract Infections	☐	Anxiety	☐
		Enlarged prostate	☐	Depression	☐
				Drug Use	☐
				Problems with Anesthesia	☐

Details of Medical History: _____

_____

_____

Cancer History:

Type: _____ **Date diagnosed:** _____

Treatment (Type, Date, and location of treatment): _____

_____

Treating Physician:_____

_____
Patient's Initials

Patient Name: _____

Past Surgical History: (Please circle and date any of the surgeries and/or procedures that you have undergone)

Coronary Bypass	Date:_____	Knee Replacement	Date:_____
Angioplasty	Date:_____	Rotator Cuff Repair	Date:_____
Pacemaker	Date:_____	Cataract	Date:_____
Cardiac Valve surgery	Date:_____	Gallbladder surgery	Date:_____
Hemorrhoidectomy	Date:_____	Hysterectomy	Date:_____
Prostate Operation	Date:_____	Prostatectomy	Date:_____
Hernia Repair	Date:_____	Appendectomy	Date:_____
Tonsillectomy	Date:_____	Hip Replacement	Date:_____
Mastectomy	Date:_____	Lumpectomy	Date:_____

Other Operations:_____

Social History:

Tobacco Use: (Present &/or Past):

☐**Never Smoked**

☐**Quit smoking When? _____ How many years did you smoke?** _____yr(s) **How many packs?** _____/day

☐**Currently Smoke** ☐**Cigarettes** ☐**Pipe** ☐**Cigars How many packs?** _____/day **How many years?**_____

☐**Chewing Tobacco**

Alcohol History: (Present &/or Past):

☐**Non Drinker**

☐**Beer** number of bottles _____ per ☐**Day** ☐**Week** ☐**Month**

☐**Wine** number of glasses _____ per ☐**Day** ☐**Week** ☐**Month**

☐**Liquor** number of glasses _____ per ☐**Day** ☐**Week** ☐**Month**

Are you: ☐**Employed/Self Employed** ☐**Unemployed** ☐**Retired** ☐**Disabled**

(Former) Occupation:_____

Name of Employer:_____ **Work Phone:** (_____)_____

Marital Status: ☐**Married** ☐**Single** ☐**Widowed** ☐**Divorced** ☐**Other**

☐**Lives Alone** ☐**Lives with Family** ☐**Lives in Nursing Home**

☐**Winter Resident** ☐**Year Round Resident**

Children: ☐ Yes ☐ No

Number_____

Health Maintenance:

Sigmoidoscopy / Colonoscopy: ☐Yes ☐No Date:_____

Findings:_____

Last Mammogram: Date: _____ Last Bone Density: Date: _____ Last Pelvic Exam: Date _____

Influenza (Flu) Shot: Date : _____ Pneumococcal Shot: Date : _____ Last Shingles Shot: Date : _____

Last EGD: Date:_____

Family Medical History: Indicate any family members with cancer, blood disease or other disease

	Age	**Disease**	**If deceased, cause of death**
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

In your opinion, are there any diseases that run in your family? ☐Yes ☐No

Please list:_____

_____

Patient's Initials

Patient Name: _____

Review of Symptoms: (Please check any **current** symptoms you have.)

General:
☐ Weight loss
How much_____
Over what time period_____
☐ Fevers
Max temp_____
☐ Chills
☐ Night sweats
☐ Fatigue

EYES:
☐ Wear Glasses/Contact Lenses
☐ Blurred Vision
☐ Double Vision

Ears, Nose, Throat:
☐ Hard of hearing or deaf
☐ Ringing in Ears
☐ Enlarged lymph nodes
☐ Chronic sinus Problems
☐ Sore throat
☐ Mouth pain/sores

CHANGES/DIFFICULTY IN:
☐ Taste
☐ Smell
☐ Voice

CARDIOVASCULAR:
☐ Chest pain/Angina Pectoris
☐ Palpitations/heart murmur
☐ Irregular heart beat Pressure

RESPIRATORY:
☐ Chronic or Frequent Cough
☐ Bloody Sputum
☐ Shortness of Breath

GASTROINTESTINAL:
☐ Difficult or painful swallowing
☐ Abdominal pain
☐ Nausea
☐ Vomiting
☐ Heartburn
☐ Indigestion
☐ Lump or sensation in throat
☐ Food sticking
☐ Bloating
☐ Belching
☐ Diarrhea
☐ Constipation
☐ Rectal bleeding
☐ Black or tarry stools
☐ Hidden blood in stool
☐ Excessive rectal gas/flatus
☐ Loss of stool/fecal accident
☐ Poor appetite
☐ Jaundice

GENITOURINARY:
☐ Kidney Stones
☐ Pelvic Pain
☐ Incontinence
☐ Burning or pain on urination
☐ Blood in Urine
☐ Difficult urination
☐ Men: Prostate problems

MUSCULOSKELATAL:
☐ Joint Pain/Arthritis
☐ Muscle or joint weakness
☐ Back Pain
☐ Bone Pain
☐ Muscle aches

NEUROLOGICAL:
☐ Numbness, tingling
☐ Arm or leg weakness
☐ Light-Headed, dizzy, fainting spells
☐ Headache
☐ Tremors

SKIN:
☐ Rashes or itching
☐ Change in skin color or moles
☐ Varicose veins
☐ Skin Cancer

PSYCHIATRIC:
☐ Anxiety/Agitation
☐ Depression
☐ Crying for no reason
☐ Insomnia
☐ Alcoholism
☐ Drug Problem (Now/Past)

HEMATOLOGIC:
☐ Easy bruising
☐ Gum or nose bleeding
☐ Blood transfusion in past

Allergies/Immunology:
☐ History of chronic infections
☐ History of allergies

ENDOCRINE:
☐ Heat or cold intolerance
☐ Excessive Skin Dryness
☐ Excessive thirst or urination
☐ Weight problem
☐ Hot flashes

BREAST:
☐ Rashes or itching
☐ Change in skin color or moles
☐ Varicose veins
☐ Skin Cancer

Gynecology:
Age at start of menses _____
Last menstrual period _____
☐ Breast pain/lump
☐ Breast discharge or rash
☐ Vaginal discharge
☐ Menstrual irregularity or abnormal bleeding

Patient Name: _____

Your treatment can be affected by any medication that you take, and it is important that your physician has updated and correct information.

Drug Allergies: List all medication allergies

Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____

Are you allergic to:

☐ Iodine ☐ Latex ☐ Shellfish ☐ CT Scan Dye / IV Contrast ☐ Eggs ☐ Peanuts

Other:_____

Type of Reaction:_____

MEDICATION LIST - List all medications (including non-prescription) that you are currently taking.

Medication	Dose	Frequency	Ordering Physician

_____
Patient's Initials