ONCOLOGY SPECIALISTS OF CHARLOTTE, PA

Patient Name_____ DOB____/_____/_____(mm/dd/yyyy)

Date of Appointment _____/_____/_____ (mm/dd/yyyy)

Please fill this form out as completely as possible and bring this to your appointment

PAST MEDICAL HISTORY (please check any medical problems that you have had in the past)

CANCER HISTORY

- ☐ Bladder cancer
- ☐ Bone cancer
- ☐ Brain cancer
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Colon cancer
- ☐ Esophageal cancer
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Prostate cancer
- ☐ Skin cancer
- ☐ Small intestine cancer
- ☐ Stomach cancer
- ☐ Uterine cancer
- ☐ Other (list) _____

MEDICAL HISTORY

- ☐ Allergies
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood transfusion
- ☐ Breast problems
- ☐ Cataracts
- ☐ Chronic bronchitis
- ☐ Cirrhosis
- ☐ Clotting disorder
- ☐ Congestive heart failure
- ☐ COPD (lung disease)
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Emphysema
- ☐ Fibrocystic breast
- ☐ GERD (heartburn)
- ☐ Glaucoma
- ☐ Heart murmur
- ☐ HIV/AIDS
- ☐ Hypertension (high blood pressure)
- ☐ Kidney disease
- ☐ Lupus
- ☐ Meningitis
- ☐ Myocardial infarction (heart attack)
- ☐ Never/muscle disease
- ☐ Osteoporosis
- ☐ Polycythemia vera
- ☐ Polymyalgia rheumatic
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Sickle cell anemia
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ TIA (transient ischemic attack)
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other (specify)_____

SURGICAL HISTORY

- ☐ Appendectomy
- ☐ Arterial bypass
- ☐ Back Surgery
- ☐ Biopsy
- ☐ Cholecystectomy (gall bladder)
- ☐ Other (list)_____
- ☐ Hysterectomy
- ☐ Splenectomy

Do you have a Living Will? ☐ Yes ☐ No

Do you have a Healthcare Power of Attorney (POA)? ☐ Yes ☐ No

If Yes, Name of POA_____

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ALLERGIES

Are you allergic to any medications? ☐ Yes ☐ No If YES, please list med and reaction:

_____

_____

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			

FAMILY HISTORY

Check below to report problems your family members have had. Please state the age when they had the problem if you know.

☐ I was adopted and my family medical history has not been disclosed to me

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Anesthesia problems							
Bleeding disorder							
Blood count disorder							
Cancer- breast							
Cancer- colon							
Cancer- leukemia							
Cancer- lung							
Cancer- lymphoma							
Cancer- melanoma (skin)							
Cancer- multiple myeloma							
Cancer- ovarian							
Cancer- sarcoma							
Cancer- other (specify)							
Clotting disorder							
Diabetes							
Heart disease							
Hypertension							
Kidney disease							
Stroke							
Other (specify)							
Alive and Age (Yes, No, n/a)							

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IMMUNIZATIONS: Please indicate any immunizations you were given by listing the estimated month and year it was administered.

Influenza ____/_____ Pneumonia ____/_____

Shingles ____/_____ HPV (genital warts) ____/_____

REVIEW OF SYSTEMS (please circle any ***current*** problems you have on the list below)

General
Fatigue / Weakness
Restless Sleep
Daytime Drowsiness
Unhappiness
Depression / Sadness
Feeling "Blue" or "Hopeless for more than 2 weeks
Lack of Motivation
Excessive Irritability
Feelings of Worthlessness
Nervous / Anxiety
Unexplained Fever >100°
Frequent Night Sweats
Unexplained Weight Loss
Unexplained Weight Gain
Excessive Thirst

Skin
Changes in Moles
Rash / Skin Spots / Growth
Bruise Easily
Itching
Excessive Hair Growth
Hair Loss

Ears/Nose/Throat
Allergy Symptoms
Hearing Loss
Ringing in Ears
Dizziness / Dizzy Spells
Nose Bleeds
Sinus Problems
Hoarseness

Eyes
Eye Pain
Double Vision
Change in Vision
Itchy / Watery Eyes

Lungs
Cough / Wheeze
Snoring/ Gasping
Difficulty Breathing
Positive TB Skin Test

Heart
Chest Pain / Pressure
Exercise Intolerance
Heart Mumur
Palpitations
Irregular Pulse
Fainting Spells
Swollen Ankles
Leg Pain with Walking

Gastrointestinal
Heartburn / GERD
Change in Bowel Habits
Difficulty Swallowing
Abdominal Pain
Nausea / Vomiting
Diarrhea / Constipation
Bloody / Black Stools
Frequent Laxative Use

Musculoskeletal
Muscle / Joint Pain
Joint Swelling
Chronic Back Pain
Gout

Genitourinary
Frequent Urine Infections
Painful Urination
Frequent Urination
Urinary Leakage / Incontinence
Blood in Urine
Overnight Urination> 2 trips
Sexual Function Problems

Male
Decrease in Force Urination
Erection Problems
Testicle Lumps / Swelling

Female
Vaginal Discharge / Itching
History of Abnormal Pap Smear
Pain / Bleeding During Intercourse
Significant Menstrual Cramps
Hot Flashes / Night Sweats

Menstrual History
Age of onset_____ or Menopause
Reg or Irreg cycle
Flow: light / moderate / heavy
Length of cycle: Days of flow_____
# of pregnancies_____/ births _____
# of miscarriages / abortions _____

Breast
Pain / Lumps / Discharge

Neurological
Frequent Headaches
Numbness / Tingling
Memory Loss
Tremor / Shaking

Explanation:_____

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ROUTINE CANCER SCREENING TESTS (list date of last test)

Mammogram	Prostate Exam/PSA
Breast Exam	Chest X-Ray
Pap Smear/Pelvic Exam	Colonoscopy/Sigmoidoscopy
Stool for Occult Blood	

SOCIAL HISTORY

Tobacco Use

(please check one)

☐ I have never smoked

☐ I have smoked, but rarely
When was the last time? _____

☐ I have quit smoking. Quit Date_____
How many packs/day? _____ # years_____

☐ I currently smoke _____ packs/day
years? _____

Other Tobacco:
☐ pipe ☐ cigar ☐ snuff ☐ chew ☐ vape
Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No

Average # of drinks/week:

5 oz. wine _____
12 oz. beer _____
1.5 oz. liquor _____

Is alcohol use a concern for you or others? ☐ Yes ☐ No

Drug Use

Do you use recreational drugs? ☐ Yes ☐ No
Have you ever used needles? ☐ Yes ☐ No
Do you currently use marijuana? ☐Yes ☐No

Sexual History

Are you sexually active? ☐ Yes ☐ No
Current sexual partners(s): ☐ male ☐ female
Birth control method _____

Exercise

Do you exercise regularly? ☐ Yes ☐ No
How often? ☐ Daily ☐ 4-6 times/week ☐ 1-3 times/week ☐ less than one time a week

What form of exercise? (ie: walking, jogging, cycling, swimming) _____

Safety

Do you use seat belts consistently? ☐ Yes ☐ No
Is violence at home a concern for you? ☐ Yes ☐ No
Are you currently in a relationship? ☐ Yes ☐ No
If yes, do you feel safe in this relationship? ☐ Yes ☐ No
Any other concerns? _____

Social Demographics

Marital Status: ☐ single ☐ engaged ☐ living w/partner
☐ married ☐ separated ☐ divorced ☐ widowed

Occupation_____
Education completed ☐ grade school ☐ high school ☐ college ☐ graduate school
Number of children _____ Who lives with you?_____
Frequent foreign travel? ☐ Yes ☐ No Where? _____