



CHARLESTON ONCOLOGY

COMPASSIONATE CARE FOR CANCER
AND BLOOD DISORDERS

A Department of
Bon Secours St. Francis Hospital

Medical History

Name: _____ Age: _____ Date: _____

Referring Physician: _____

Other Physicians: _____

Chief Complaint: Please explain the reason why you are here today: _____

✓ Check if YES

- | | | |
|---|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diverticular Disease/Polyp | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Other Collagen Vascular Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GYN Problems | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart Disease/Murmur | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Hepatic Disease | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Severe Anxiety |
| <input type="checkbox"/> Colonoscopy, Date _____ | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke/Paralysis |
| <input type="checkbox"/> Cystitis (Bladder Infection) | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease or Goiter |
| <input type="checkbox"/> Depression | <input type="checkbox"/> HIV | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> Kidney Infection | |
| | <input type="checkbox"/> Lupus | |

List other Medical Problems of Past Surgeries (Include approximate dates): _____

Have you ever Had:

Any other cancer? Yes _____ No _____ If yes, please explain: _____

Previous Radiation treatments? Yes _____ No _____ If yes, please explain: _____

Previous Chemotherapy? Yes _____ No _____ If yes, please explain: _____

Are you currently under home health or hospice care? Home Health Hospice _____

Name: _____

Family History

Has anyone in your family had cancer? Yes No

If Yes, please list type and relationship: _____

Social History

Occupation: _____

Marital Status: Married Divorced Separated Single Widow(ed)

Name of Spouse or Significant other: _____

Does principle care person live with you? Yes No **Children(#):** _____

Is this person willing to help? Yes No **Ages:** _____

Health of Principle Care Person: _____

Current Living Conditions: Live Alone Live with family/others

Live in: House Nursing/Personal care Home Assisted living

Do you have... (If yes please explain)

Transportation problems? Yes No _____

Religious Preference (Optional)? Yes No _____

Any special requirements/disability? Yes No _____

Financial/Homecare Needs? Yes No _____

Living Will? Yes No **Do you want info?** Yes No

Smoke Cigarettes? Yes No In the Past **Packs per day:** _____

When did you quit? _____ **Years Smoked:** _____

Drink Alcohol? Yes No **Frequency?** Occasional Moderate Heavy

Female Gynecologic History

Age at first menstrual period: _____ Age of final Menstrual period, if applicable: _____

Have you had irregular bleeding? Yes No Do you take birth control? Yes No

Hormone Replacement Therapy: Yes No In the Past

Pregnancies (#): _____ Live Births (#): _____ Miscarriages (#): _____

Living Children (#): _____ Age at first childbirth: _____

Breast Feeding? Yes No Was this your first Breast Biopsy? Yes No

Are you currently pregnant? Yes No ****If yes, notify doctor or nurse****

Medication History

Pharmacy: _____ Phone #: _____

Please list medication currently using prescribed, over the counter, herbal, or recreational:

<u>Medication</u>	<u>Dosage</u>	<u>How Often?</u>	<u>Prescribing Doctor?</u>
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1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

During the course of treatment, please inform the nurse of any changes to your medications

Have you received an influenza vaccination (flu season only)? Yes No

Allergies

Allergy to X-ray dye? Yes No Allergy to drugs? Yes No

Allergy to Foods? Yes No Other Allergies? Yes No

List Allergies/ Describe Reaction:

Pain Assessment

Do you have Pain? Yes No

Please rate your pain today? 1- Being no pain and 10- extreme pain _____

What pain medicines or other methods do you use to relieve pain? _____

Is there any other information that you feel is important for us to know? _____

Review of Systems

✓ Please Check all that apply

Constitutional

- Fever
- Chills
- Night Sweats
- Loss of Appetite
- Fatigue
- Weight Gain
- Weight Loss
- Other: _____

Eyes

- Change in Vision
- Loss of Vision
- Cataracts
- Contacts
- Glasses
- Other: _____

Ears

- Change in Hearing
- Deafness
- Ringing in ears
- Other: _____

Nose

- Nasal Stuffiness
- Bleeding
- Sinus Congestion
- Other: _____

Mouth

- Dentures
- Dental Problems
- Ulcers/Sores
- Other: _____

Throat

- Sore Throat
- Difficulty Swallowing
- Hoarseness
- Other: _____

Cardiovascular

- Chest Pain
- Irregular Heartbeat
- Pacemaker
- Fainting Spells
- Swelling in Legs

- Cold Extremities
- Intermittent lower leg calf pain when walking
- Other: _____

Musculoskeletal

- Bone Pain
- Joint Pain
- Artificial Joints
- Leg Pain when walking
- Other: _____

Respiratory

- Shortness of Breath
- Shortness of Breath on Exertion
- Cough
- Chest Pain
- Coughing up Blood
- Require Oxygen
- Other: _____

Gastrointestinal

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in Stools
- Abdominal Pain
- Difficulty Swallowing
- Pain with Swallowing
- Hemorrhoids
- Yellowing of Skin
- Change in Stools
- Other: _____

Endocrine

- Change in Thirst
- Frequent Urination
- Thyroid Problem
- Other: _____

Skin

- Rashes
- Sores
- Changes in Moles
- Lumps
- Other: _____

Psychiatric

- Depression
- Anxiety
- Nervousness
- Sleep Problems
- Other: _____

Genitourinary: Male

- Frequency of Urination
- Urgency of Urination
- Urinating Frequently at Night
- Straining with Urination
- Painful Urination
- Blood in Urine
- Sexual Dysfunction
- Leaking of Urine
- Other: _____

Genitourinary: Female

- Frequency of Urination
- Urgency of Urination
- Urinating Frequently at Night
- Straining with Urination
- Painful Urination
- Blood in Urine
- Sexual Dysfunction
- Leaking of Urine
- Abnormal Vaginal Bleeding
- Painful Intercourse
- Other: _____

Breasts

- Lump
- Nipple Discharge
- Skin Changes
- Pain
- Other: _____

Hematologic/Lymphatic

- Bruising
- Bleeding
- Enlarged Lymph Nodes
- Other: _____

Neurologic

- Headache
- Numbness
- Tingling
- Weakness
- Seizures
- Dizziness
- Difficulty Speaking
- Paralysis
- Unsteady Gait
- Recent Falls
- Loss of Bladder Control
- Loss of Bowel Control
- Other: _____