EMORY WINSHIP CANCER INSTITUTE
A Cancer Center Designated by the National Cancer Institute

Patient History Form

FOR CLINIC STAFF ONLY [PLACE STICKER HERE]

Patient Name:
MRN:
DOB:

Preferred method of contact (please circle): Home Work Cell
Reason for visit/referral: _____

_____

Please list your referring physician(s) and indicate if you would like them to be informed of your health-related decisions and treatment plans.

Primary Care Physician _____ Send Correspondence? Y or N

Phone Number ( ) _____ Fax Number ( ) _____

City _____ State _____ Zip Code _____

Physician Name _____ Send Correspondence? Y or N

Specialty_____ Phone Number ( ) _____ Fax Number ( ) _____

City _____ State _____ Zip Code _____

Physician Name _____ Send Correspondence? Y or N

Specialty_____ Phone Number ( ) _____ Fax Number ( ) _____

City _____ State _____ Zip Code _____

Physician Name _____ Send Correspondence? Y or N

Specialty_____ Phone Number ( ) _____ Fax Number ( ) _____

City _____ State _____ Zip Code _____

Medical History:

Allergies: *Please list all medication and dye-related allergies.*

Medication	Allergic Reaction

Medical History (continued)**:**

Date of Last Colonoscopy: _____

*Result: Normal (circle) Abnormal (explain):*_____

Date of Last Pap Smear: _____

Result: Normal (circle) Abnormal (explain): _____

Date of Last Mammogram: _____

*Result: Normal (circle) Abnormal (explain):*_____

Breast Self Examination: Do you perform breast self-examinations? Y or N

If yes, how frequently? Monthly (circle) other (please specify) _____

Pregnancy History:

Age of first pregnancy: _____# of pregnancies: _____

Lactation History:

Have you ever breast fed: Y or N

If yes, for how long? (total for all children, if possible): _____

Menstrual History:

Date of Last Menstrual Period: _____ Age of First Menstrual Period_____

Are your menstrual periods regular: Y or N If yes, # of days in cycle: _____

Hormone Use:

Have you **ever** used hormone replacement therapy? (please circle) Y N

If yes, for how long? _____ Name of medication _____

Are you **currently** taking hormone replacement? (please circle) Y N

If yes, for how long? _____ Name of medication _____

Have you ever taken oral contraceptives? (please circle) Y N

Are you presently bothered by symptoms related to menopause such as hot flashes? (please circle) Y N Uncertain

If you are a male, have you had a PSA Test? (please circle) Y N Uncertain

*Result: Normal (circle) Abnormal (explain):*_____

Prior Hospitalizations/Medical Problems:

Have you ever been diagnosed with a tumor (benign or cancerous) previously? Y or N

If yes, was it the same type of tumor? (eg. breast or skin) Y or N

Please list all previous cancers:

Cancer	Date of Diagnosis	Date of Last Treatment

Have you ever had or do you currently have any of the following: (please check all that apply)

- ☐ Diabetes Mellitus
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Adrenal Problems
- ☐ Addison's Disease
- ☐ Cushing's Disease
- ☐ Hyperparathyroidism
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Peptic Ulcer Disease
- ☐ Gastric Reflux
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Bleeding Disorders
- ☐ Leukemia/Lymphoma
- ☐ Thrombocytopenia /ITP/TTP
- ☐ Tuberculosis
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Pneumonia
- ☐ Hypertension
- ☐ Peripheral Vascular Disease
- ☐ Aortic Aneurysm (thoracic or abdominal)
- ☐ Stroke or TIA
- ☐ Heart Attack/Angina
- ☐ Cardiac Disease
- ☐ Congestive Heart Failure
- ☐ Pulmonary Edema
- ☐ Pulmonary Hypertension
- ☐ High Cholesterol
- ☐ Acute Pancreatitis
- ☐ Chronic Pancreatitis
- ☐ Kidney Stones
- ☐ Gall Stones
- ☐ Gastrointestinal Bleeding
- ☐ Emphysema

Please list all previous hospitalizations (including surgery): _____

_____

_____

Social History:

Do you or have you ever:

Used tobacco (any form)? Y or N

If yes, how much and for how long? _____

Drank alcohol? Y or N

Number of beers/week: _____ # of years _____

Number of shots/drinks of hard alcohol/week: _____ # of years ____

Number of glasses of wine/week: _____ # of years _____

Do you or have you ever used recreational drugs (cocaine, heroine, marijuana) or been addicted to prescription drugs? Y or N

If yes, please describe:_____

What is your current occupation? _____

If not your present occupation, what is the occupation you held for the longest period of time?

_____ For how long? _____

To the best of your knowledge, were you ever exposed to any occupational hazards (such as asbestos, radiation, coal dust, etc.)? _____

Family History:

Have Any Members of Your Family Ever Had Cancer? (Please List as appropriate):

Paternal Grandfather_____Maternal Grandfather_____

Paternal Grandmother_____Maternal Grandmother_____

Father_____ Mother_____

Sibling_____Sibling_____

Sibling_____Sibling_____

Child_____ Child_____

Others (list): _____

Review of Systems:

Do you presently have any of the following (please check all that apply):

Constitutional:

- ☐ Weakness
- ☐ Fatigue
- ☐ Lack of Appetite
- ☐ Fevers
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Malaise
- ☐ Chills
- ☐ Difficulty Sleeping

Psychological:

- ☐ Depression
- ☐ Anxiety
- ☐ Agitation
- ☐ Suicidal Thoughts
- ☐ Memory difficulty/forgetfulness

Neurologic:

- ☐ Extremity/muscular weakness
- ☐ Gait instability
- ☐ Dizziness
- ☐ Blurry vision
- ☐ Paralysis
- ☐ "Pins and Needles" (parasthesias)
- ☐ Loss of vision
- ☐ Headaches
- ☐ Double vision
- ☐ Loss of sensation
- ☐ Difficulty in speaking
- ☐ Blackouts
- ☐ Confusion/Difficulty in thinking

Endocrine:

- ☐ Goiter
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Weight loss
- ☐ Weight gain
- ☐ Tremors
- ☐ Change in voice
- ☐ Increase in facial/body hair
- ☐ Decrease in facial/body hair
- ☐ Change in menstrual periods/Loss of menstrual periods (not related to menopause)
- ☐ Excessive thirst
- ☐ Increased urination
- ☐ Increased appetite

Skin:

- ☐ Dryness of skin
- ☐ Excessive itching
- ☐ Rash (persistent)
- ☐ Change in skin color
- ☐ Changes in finger/toe nails
- ☐ Skin ulcers/bruising
- ☐ New moles/spots

Lymphatics:

- ☐ "Swollen nodes or glands"
- ☐ Bumps under arms, in groin or in neck
- ☐ Swelling of arms or legs

Cardiovascular:

- ☐ Arrhythmia or "funny heart beat"
- ☐ Chest pain
- ☐ Heart Attack
- ☐ Palpitations
- ☐ Tightness of Chest
- ☐ Shortness of breath
- ☐ Exercise intolerance
- ☐ Need to sleep on more than 1 pillow
- ☐ Calf pain with walking distances
- ☐ Swelling of the legs
- ☐ Heart Murmur
- ☐ Shortness of breath lying down/unable to lie flat

Respiratory:

- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Wheezing
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Pain with breathing
- ☐ Stridor
- ☐ Hay fever

Ears, Eyes and Throat:

- ☐ Blurred vision
- ☐ Spots in your eyes
- ☐ Pain in the eyes
- ☐ Eye infections
- ☐ Difficulty hearing
- ☐ Ringing in the ears
- ☐ Pain in the ears
- ☐ Discharge from the ears
- ☐ Nosebleeds
- ☐ Rhinorrhea (runny nose)
- ☐ Chronic stuffy nose
- ☐ Sinus trouble
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Neck Pain
- ☐ Throat Pain
- ☐ Dental problems
- ☐ Oral sores
- ☐ Bleeding gums
- ☐ Decreased vision

Gastrointestinal:

- ☐ Anorexia (loss of appetite)
- ☐ Early satiety
- ☐ Nausea
- ☐ Vomiting
- ☐ Jaundice
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody vomiting
- ☐ Blood in stool
- ☐ Pain with bowel movements
- ☐ Pain with swallowing/difficulty swallowing
- ☐ Unable to swallow foods
- ☐ Black/Tarry stools
- ☐ Stools that float/oily in appearance/foul smelling
- ☐ Food intolerance (i.e. fatty foods)
- ☐ Abdominal cramping/bloating

Urinary Tract:

- ☐ Pain with urination
- ☐ Burning with urination
- ☐ Incomplete voiding
- ☐ Frequency
- ☐ Urgency (think you have to go but you don't)
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ large volume of urine
- ☐ Difficulty starting to urinate
- ☐ Incontinence
- ☐ Repeated Urinary Tract Infections

Genital Tract:

Male:

- ☐ Difficulty attaining an erection
- ☐ Persistent erections
- ☐ Discharge from penis
- ☐ Pain with intercourse
- ☐ Testicular Pain
- ☐ Mass in testicles/penis

Female:

- ☐ Vaginal discharge
- ☐ Pain with intercourse
- ☐ Vaginal/Labial Mass/ Ulcer
- ☐ Change in menstrual flow
- ☐ "extra" periods/excessive bleeding

Musculoskeletal:

- ☐ Painful joints
- ☐ Swollen joints
- ☐ Changes in limbs (lumps, swelling)
- ☐ Muscle pain
- ☐ Back pain
- ☐ Pain down either/both legs

Medical Devices/Implants/Other:

- ☐ Indwelling catheter
- ☐ Hepatic Infusion Pump
- ☐ Dialysis access
- ☐ Insulin pump
- ☐ Automated Intracardiac Defibrillator (AICD)
- ☐ Pacemaker
- ☐ VP Shunt
- ☐ Peritoneal Dialysis Catheter
- ☐ Orthopedic implant