

Carolina BioOncology Institute, PLLC
HEALTH HISTORY FORM

Name: _____ DOB: _____ Date: _____
 Do you have an Advance Directive? (circle one) Yes No If no, would you like information? (circle one) Yes No

Birthplace: _____
 Highest level school: _____
 Occupation: _____
 Previous Occupations: _____
 diagnosed: _____
 Hobbies: _____
 Do you exercise? _____ Type: _____

Last physical exam? _____
 Last dental exam? _____
 Last chest xray? _____

Tobacco Products:
 Chewing TOB: _____ Cigarettes _____ Pipe _____
 Current Smoker? _____ packs per day: _____
 # years: _____
 Past smoker, date quit: _____ packs per day : _____
 # years smoked ? _____
 Alcohol? _____ type/amount per week: _____
 Caffeine? _____ type/amount per day: _____
 Recreational drugs? _____
 Weight? _____ Ideal Weight: _____
 Height? _____

Please list all **medical conditions/diseases:** _____ Date _____

ALLERGIES: including food, drug, and environmental: _____

Please list all **surgeries/ procedures:** _____ Date: _____

List any exposure to toxins or radiation such as asbestos, benzenes, other chemicals: _____

Please list **hospitalizations:** _____ Date: _____

Have you ever been in the military? _____
 dates _____ locations _____
 Have you ever worked in an industrial plant or hospital? _____
 dates _____ locations _____
 History of severe blistering/sunburns as a child? _____

Please list all **medications** including herbal and alternative

<u>Drug:</u>	<u>Dose:</u>	<u>How often:</u>	<u>Start date:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing and why you were referred:

PAST MEDICAL HISTORY (Review of Systems)

Please **CIRCLE** any of the following **symptoms** and/or **conditions** that you **currently have or had in the past:**

CANCER: melanoma / breast / prostate / lung / colon / pancreatic / ovarian / testicular / leukemia / lymphoma

INFECTIONS: measles / mumps / chickenpox / whooping cough / scarlet fever / diphtheria / smallpox / hepatitis / tuberculosis (TB) / polio / AIDS or HIV / mononucleosis / rheumatic fever

GENERAL: change in weight / change in appetite/ weakness or paralysis / tire easily / fevers / night sweats / chills/ hot flashes / sensitivity to cold or heat

SKIN: rashes/ itchiness / bruising / mole changes / nail changes / slow wound healing / hives/ eczema

EYES: double vision / blurry vision/ dry eyes / cataracts/ glaucoma/ flashing light

EARS: hearing changes / hearing loss / ringing in ears / discharge from ears / ear pain / vertigo

NOSE: frequent nose bleeds / sinus problems / loss of smell

MOUTH & THROAT: hoarseness / sore throat / sore gums

NECK: lumps/ swelling / difficulty swallowing

BREAST: lumps / pain / nipple discharge / redness / rash

RESPIRATORY: shortness of breath / cough / bloody sputum / wheezing / difficulty breathing /
hay fever / asthma / bronchitis / pneumonia / obstructive sleep apnea

CARDIAC: chest pain / fluttering heart / swelling in hands or feet/ purple lips or fingers / mitral valve prolapse /
arrhythmia/ atrial fibrillation / coronary artery disease or heart disease / hypertension or blood pressure problems

GASTROINTESTINAL: abdominal pain / diarrhea / constipation / nausea / vomiting / heartburn / ulcer / hernia /
hemorrhoids / frequent belching

ENDOCRINE: diabetes mellitus / thyroid disease

MUSCULOSKELETAL: joint pain / muscle stiffness / leg cramps / muscle spasms / arthritis / back problems

NEUROLOGICAL: fainting spells / dizziness / seizures / memory loss / poor coordination / epilepsy / headaches /
migraine headaches / stroke / speech problems / difficulty swallowing

PSYCHOLOGICAL: depression / anxiety / drug or alcohol abuse

HEMATOLOGICAL: anemia / easy bruising / history of transfusions / blood disorder

URINARY: burning or pain with urination / urinary tract infection / kidney stone / blood in urine /
frequent urination / difficulty with urination / kidney disease

GENITAL:

Men: discharge from penis / pain / lump in testicles / impotence / sexually transmitted disease

Women: bleeding or spotting between menses / itching in vaginal area / pain with intercourse /
sexually transmitted disease

GYNECOLOGICAL HISTORY:

Age menstrual cycle began? _____

Average # of days menses last ? _____

Average # of days between menses? _____

Is your flow heavy? _____

Date of last menses? _____

Date of last pelvic exam? _____

Pelvic exam results: _____

Date of last mammogram? _____

Mammogram results: _____

Are you taking birth control? Yes No

if so, what type _____ # years: _____

Do you use hormone replacement therapy? Yes No

if so , what type _____ # years: _____

of pregnancies? _____

of preterm births? _____

of full term births? _____

Please list any additional information you would like your doctor to know about your medical history:

FAMILY HISTORY

Has any blood relative had any of the following:

	<u>Relationship</u>	<u>Type</u>
Cancer	no yes _____	_____
Diabetes	no yes _____	_____
Heart Disease	no yes _____	_____

	<u>Relationship</u>		<u>Relationship</u>
high blood pressure	no yes _____	psychosis	no yes _____
stroke	no yes _____	suicide	no yes _____
epilepsy	no yes _____	leukemia	no yes _____
allergies	no yes _____	migraine headaches	no yes _____
anemia	no yes _____	obesity	no yes _____
bleeding tendency	no yes _____	thyroid disease	no yes _____
asthma	no yes _____	ulcer	no yes _____
chronic lung disease	no yes _____	high cholesterol	no yes _____
drug/alcohol problem	no yes _____	kidney disease	no yes _____
depression	no yes _____	glaucoma	no yes _____
gout	no yes _____	tuberculosis	no yes _____

If the following relatives are living, please list age and health status (good, fair, poor). If deceased list age and cause of death.

Father _____	Sister _____
_____	_____
Mother _____	Son _____
_____	_____
Brother _____	Daughter _____
_____	_____

The questions on this form have been answered to the best of my knowledge.

Signature

Date

Physician's Comments:

Physician's Signature

Date