

Carolina BioOncology Institute, PLLC
HEALTH HISTORY FORM
(For Yes/No questions please circle your answer)

Name _____ Date of Birth _____ Current Date _____

Do you have an Advance Directive Yes / No If no, would you like information Yes / No

Date of last physical exam _____ Date of last dental exam _____ Date of last chest xray _____

Highest level school completed _____ Exercise Regularly: Yes / No If yes, type _____

EXPOSURE HISTORY:

Birthplace _____ Hobbies _____

Occupation _____ Previous Occupations _____

List any exposure to toxins or radiation (benzenes, other chemicals, asbestos, etc) _____

Current/Previous Military: Yes / No If yes, dates _____ Locations _____

Worked in an industrial plant or hospital: Yes / No If yes, dates _____ Locations _____

History of blistering sunburns as a child: Yes / No

TOBACCO PRODUCTS:

Circle if used: Chewing Tobacco / Cigarettes / Pipe / Cigars / other

Currently smoke: Yes / No If yes, packs per day _____ # of years _____

If past smoker, date quit _____ Packs per day smoked _____ # years smoked _____

Use alcohol: Yes / No Type _____ Amount per week _____

Drink caffeine: Yes / No Type _____ Amount per week _____

Use recreational drugs: Yes / No

Please list all **Allergies** (including food, drug, environmental) _____

Please list all **Medical Conditions/Diseases** and Date Diagnosed:

Please list all **Surgeries/Procedures** you've had and Date Performed:

Please list all **Hospitalizations** and Date Hospitalized:

CHIEF COMPLAINT

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

PAST MEDICAL HISTORY CONTINUED:

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 periods / itching in vaginal area / pain with intercourse / sexually transmitted disease

GYNECOLOGICAL HISTORY (for women):

Age at first period	_____	Average # of days period lasts	_____
Average # of days between periods	_____	Is your flow heavy	_____
Date of last period	_____	Pap Smear results	_____
Date of last pap smear	_____	Mammogram results	_____
Date of last mammogram	_____	# of preterm births	_____
# of pregnancies	_____		
# of full term births	_____		
Are you taking birth control:	Yes / No	If yes, what type	_____ # years _____
On hormone replacement therapy:	Yes / No	If yes, what type	_____ # years _____

FAMILY HISTORY:

Please circle yes or no if a blood relative has ever been diagnosed with any of the following and list their relationship to you (such as father, mother, paternal grandmother, maternal uncle, etc).

	Yes / No	Relationship To You		Yes / No	Relationship To You
diabetes	_____	_____	psychosis	_____	_____
heart disease	_____	_____	suicide	_____	_____
high blood pressure	_____	_____	leukemia	_____	_____
stroke	_____	_____	migraines	_____	_____
epilepsy	_____	_____	obesity	_____	_____
allergies	_____	_____	thyroid disease	_____	_____
anemia	_____	_____	ulcer	_____	_____
bleeding tendency	_____	_____	high cholesterol	_____	_____
asthma	_____	_____	kidney disease	_____	_____
chronic lung disease	_____	_____	glaucoma	_____	_____
drug/alcohol problem	_____	_____	tuberculosis	_____	_____
depression	_____	_____	gout	_____	_____

FAMILY HISTORY FOR COMMON HEREDITARY CANCER SYNDROMES

Please circle yes or no if a blood relative has ever been diagnosed with any of the following and list their relationship to you (such as father, mother, paternal grandmother, maternal uncle, etc) and their age at diagnosis.

<u>Breast & Ovarian Cancer</u>	Yes / No	Relationship to You	Age at Diagnosis
Breast cancer before age 50	_____	_____	_____
Ovarian cancer	_____	_____	_____
Breast & ovarian cancer in an individual or family	_____	_____	_____
Male breast cancer	_____	_____	_____
Breast cancer in both breasts or multiple primary breast cancers	_____	_____	_____
2 or more breast or ovarian cancers in an individual or family	_____	_____	_____
Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer	_____	_____	_____

FAMILY HISTORY FOR COMMON HEREDITARY CANCER SYNDROMES CONTINUED

Colon & Uterine Cancer

	Yes / No	Relationship to You	Age at Diagnosis
10 or more colon polyps found in a lifetime	Yes / No	_____	_____
Uterine cancer before age 50	Yes / No	_____	_____
Colorectal cancer before age 50	Yes / No	_____	_____
Both uterine & colorectal cancer in an individual or family	Yes / No	_____	_____
2 or more uterine or colorectal cancers in an individual or family	Yes / No	_____	_____
Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer in an individual or family	Yes / No	_____	_____

Any other family history of cancer: Yes / No

If yes, list type of cancer and relationship of family member _____

If additional room needed, continue on back. Health status= good, fair, poor

<u>Father</u>		<u>Mother</u>	
If living: Age _____ Health Status _____		If living: Age _____ Health Status _____	
If deceased: Age at death _____ Cause of death _____		If deceased: Age at death _____ Cause of death _____	

<u>Sister</u>		<u>Sister</u>	
If living: Age _____ Health Status _____		If living: Age _____ Health Status _____	
If deceased: Age at death _____ Cause of death _____		If deceased: Age at death _____ Cause of death _____	

<u>Brother</u>		<u>Brother</u>	
If living: Age _____ Health Status _____		If living: Age _____ Health Status _____	
If deceased: Age at death _____ Cause of death _____		If deceased: Age at death _____ Cause of death _____	

<u>Son</u>		<u>Son</u>	
If living: Age _____ Health Status _____		If living: Age _____ Health Status _____	
If deceased: Age at death _____ Cause of death _____		If deceased: Age at death _____ Cause of death _____	

<u>Daughter</u>		<u>Daughter</u>	
If living: Age _____ Health Status _____		If living: Age _____ Health Status _____	
If deceased: Age at death _____ Cause of death _____		If deceased: Age at death _____ Cause of death _____	

Any additional information you would like to share with your doctor _____

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

Patient Signature

Date

Physician's Comments:

Physician's Signature

Date