Carolina BioOncology Institute, PLLC

HEALTH HISTORY FORM

(PLEASE COMPLETE ALL FIELDS)

Name:_____ Date of Birth:_____ Current Date:_____

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

Physician/Provider List (PCP, Referring - any provider you would like to receive a copy of your notes)

Physician/Provider Name	Phone number	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS:

*Please **CIRCLE** any of the following **symptoms** that you **currently have**:*

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

EYES: double vision / blurry vision / dry eyes / cataracts / 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

CARDIAC: chest pain / fluttering heart / swelling in hands or feet / purple lips or fingers

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

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

NEUROLOGICAL: fainting spells / dizziness / seizures / memory loss / poor coordination/ speech problems / difficulty swallowing

PSYCHOLOGICAL: stress / nervousness / drug or alcohol abuse

HEMATOLOGICAL: easy bruising / history of transfusions

URINARY: burning or pain with urination /blood in urine /frequent urination / difficulty with urination

GENITAL:

Men: discharge from penis / pain / lump in testicles / impotence

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

Have you ever had a pneumonia vaccine: yes / no If yes, when:_____
Have you ever had a shingles vaccine: yes / no If yes, when:_____
Most recent flu vaccine: _____

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

_____
_____
_____
_____

MEDICAL CONDITIONS/DIAGNOSIS:	**DATE DIAGNOSED:**
Ex. Diabetes	*2009*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

GYNECOLOGICAL HISTORY (for women):

# of pregnancies _____
# of full term births _____
# of preterm births _____
Age at first birth _____
Age at first period _____
Date of last period _____
Average # of days between periods _____

Contraceptive Hormone Use: Yes / No # of years _____
Post-Menopause Use: Yes / No # of years_____
Other Hormone Use: Yes / No # of years_____

Date or year of last pap smear: _____
Results:_____
Date or year of last mammogram:_____
Results:_____

Menopause Status: Pre / Peri / Post / Unknown
Age at menopause _____ Reason: Natural / Removal ovaries / Removal uterus / Total hysterectomy / Surgical / Other

FAMILY HISTORY: Please circle yes or no if a blood relative has ever been diagnosed with any of the following:

		Relationship To You			Relationship To You
diabetes	Yes / No	_____	thyroid disease	Yes / No	_____
heart disease/attack	Yes / No	_____	anemia	Yes / No	_____
high blood pressure	Yes / No	_____	leukemia	Yes / No	_____
stroke	Yes / No	_____	bleeding tendency	Yes / No	_____
osteoporosis	Yes / No	_____	chronic lung disease	Yes / No	_____
kidney disease	Yes / No	_____	melanoma	Yes / No	_____

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:

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

Colon & Uterine Cancer			
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 & relationship of family member:_____
_____

Please list Health Status as Good, Fair, or Poor

Father
If living: Age_____ Health Status_____
If deceased: Age at death_____Cause of death_____

Mother
If living: Age_____ Health Status_____
If deceased: Age at death_____Cause of death_____

Sister
If living: Age_____ Health Status_____
If deceased: Age at death_____Cause of death_____

Sister
If living: Age_____ Health Status_____
If deceased: Age at death_____ Cause of death_____

Brother
If living: Age_____ Health Status_____
If deceased: Age at death_____Cause of death_____

Brother
If living: Age_____ Healt Status_____
If deceased: Age at death_____ Cause of death_____

Son
If living: Age_____ Health Status_____
If deceased: Age at death_____Cause of death_____

Son
If living: Age____ Health Status_____
If deceased: Age at death_____ Cause of death_____

Daughter
If living: Age_____ Health Status_____
If deceased: Age at death_____ Cause of death_____

Daughter
If living: Age____Health Status_____
If deceased: Age at death_____ Cause of death_____

SOCIAL HISTORY:

Tobacco use: current / infrequent / past / never
If current, # of years_____ # of packs per day _____
If past, # of years quit_____ # of packs per day _____
Type of tobacco used: cigarettes / cigars /chewing tobacco / pipe / snuff

Alcohol use: current / infrequent / past / never
If current, # of drinks per week _____ or day _____
If past, # of years quit _____

Illicit drug use: current / past / never Type: marijuana / cocaine / other _____

Marital Status: divorced/ legally separated / life partner / married/ married-separated / single / widowed

Birthplace_____

Hobbies_____

Occupation_____

Where do you live: house or apt / nursing home / assisted living facility / incarcerated / homeless

Who lives with you: alone / spouse / significant other / children / parents / friends / others

Circle any exposure to the following: asbestos / benzene / coal / lead / mercury/ radiation / red dye #3 / petroleum products / Xylene / other_____

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

How often are you active: never / daily activities / occasional exercise / light exercise / regular exercise / extensive exercise

What is your current diet: regular diet / dietary supplements / liquid diet / diabetic diet / vegetarian / tube feeds / TPN

ALLERGIES: List any known drug, food, or environmental allergies:

To what	What type of reaction	Severity of reaction
_____	_____	mild / moderate / severe / life threatening
_____	_____	mild / moderate / severe / life threatening
_____	_____	mild / moderate / severe / life threatening

MEDICATIONS, INCLUDING HERBAL AND OVER THE COUNTER MEDICINES: *(If additional room needed, continue on back)*

Name and Dose	How Often Taken	Start Date	Reason for Taking
Ex: Hydrochlorothiazide 12.5 mg	*Twice a day*	*2013*	*Hypertension*

Please ensure conditions listed under reason for taking are also recorded in the medical condition/diagnosis box

CHRONOLOGICAL HISTORY OF YOUR CANCER TREATMENT*(please include all chemotherapy and radiation in the order you received):*

Name	**Start Date**	**Stop Date**
Ex. Taxol; lung radiation	*May 1st , 2013*	*May 30th, 2013*

Date of relapse/progression (if applicable):

_____

Date and type of last scans (if applicable):

_____

Any additional information you would like to share with doctor:

_____

_____

_____

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

_____ _____

Patient Signature Date

rev 12/2008, 12/2010, 1/13, 12/2014, 01/2018,2/2018