Patient History Form

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____

Cell Phone: _____ Work Phone: _____

Emergency Contact & Phone: _____

Providers

Referring physician:	Medical Oncologist:
Primary Care Physician:	Other Provider:
Other Provider:	Other Provider:

Medications

Medications	Dose	Times per Day

If you need to list more medications, please write them on an additional sheet of paper

Allergies ☐ *No Allergies*

Allergy	Allergic Reaction
Allergy to Medications? ☐ Y ☐ N Explain:	
Allergy to IV Contrast? ☐ Y ☐ N Explain:	

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Prior history of cancer? ☐ Y ☐ N Explain:
Prior radiation therapy treatment? ☐ Y ☐ N Explain:
Prior chemotherapy? ☐ Y ☐ N Explain:
Are you pregnant, or still want to have children? ☐ Y ☐ N
Do you have a pacemaker or defibrillator? ☐ Y ☐ N Explain:
If you have been diagnosed with head or neck cancer, who is your dentist?

Medical History

Check all that apply			
☐	Alcoholism/Drug abuse	☐	HIV/AIDS
☐	Anemia	☐	Hypothyroidism/Thyroid Disease
☐	Arthritis	☐	Jaundice
☐	Asthma/Bronchitis	☐	Migraine Headaches
☐	Autoimmune Disease	☐	Muscular Disorder
☐	Depression/Anxiety/Bipolar/Suicidal	☐	Renal *(kidney)* Disease
☐	Diabetes *(type: _____)*	☐	Seizures
☐	Emphysema *(COPD)*	☐	Stroke
☐	Heart Disease	☐	Ulcerative Colitis/Crohn's Disease
☐	High Blood Pressure *(hypertension)*	☐	Other:
☐	High Cholesterol	☐	Other:

Surgeries or Recent Hospitalizations

Type/Reason	**Date (MM/YY)**	**Location/Facility**

Family Cancer History

Relatives with History of Cancer (Relationship)	Cancer Type	Age at Diagnosis

Social History

Occupation:	☐ Retired ☐ Unemployed ☐ L.O.A. ☐ Disabled
Employer:	Years of Education/Highest Degree:
Exposure to Hazardous Materials? ☐ Y ☐ N Explain:	
Do you drink alcohol? ☐ Y ☐ N	Number of drinks per day:
Smoke Cigarettes? ☐ Y ☐ N	Type: _____ Packs/day: _____ # of Years: _____
	Age at start: _____ Age at stop: _____
Other Tobacco (check all that apply): ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew	

Current Symptoms

Check all that apply							
☐	Fever	☐	Visual Changes	☐	Swollen Lymph Node	☐	Bloody Stools
☐	Chills	☐	Double Vision	☐	Masses	☐	Hemorrhoids
☐	Weight Loss	☐	Ear Pain	☐	Chest Pain	☐	Urinary frequency
☐	Fatigue	☐	Ringing	☐	Shortness of Breath	☐	Burning
☐	Headaches	☐	Hoarseness	☐	Heartburn	☐	Bleeding
☐	Numbness	☐	Difficulty Swallowing	☐	Nausea	☐	Leg Swelling
☐	Seizures	☐	Cough	☐	Diarrhea	☐	Muscle Weakness
☐	*Other:*			☐	*Other:*		
Pain: Are you in Pain? ☐ Y ☐ N		Scale of 1 – 10:		Medications for Pain:			

Other important information: _____

(Please detail any other important information on an additional sheet of paper)

Patient Name: _____