

PATIENT HISTORY FORM

Midwest Cancer Care

Full Name _____

Date of Birth ____/____/____

Today's Date ____/____/____

Chief Complaint (main reason for your visit today):

History of Present Illness:

Symptoms (problems you have felt):

Duration (how long they have lasted):

Frequency (how often they occur):

Severity (how bad the symptoms are):

Associations (what brings them on, makes them go away, or makes them better/worse):

Effects (how do the symptoms affect your normal activities):

Past Surgical History (and other major procedures / interventions)

Surgery or Procedure	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Past Medical History (other medical problems):

Diagnosis	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____

Primary Care Physician: _____

Referring Physician (if different): _____

Other doctors you would like to receive a copy of our note:

Leave blank for Physician Notes

Family History by Cancer Type, Blood Disease or Other Major Medical Illness.

Please indicate Paternal (father's side) or Maternal (mother's side) and write approximate age at time of diagnosis in table

Relative	Breast Cancer	Colon Cancer	Ovarian Cancer	Prostate Cancer	Other Cancer	Blood Disease	Other Disease	Other notes
Example:Father				Age 68		X		Also had blood clotting disorder
Your Father								
Your Mother								
Your Brothers								
Your Sisters								
Your Sons								
Your Daughters								
Paternal GF								
Paternal GM								
Maternal GF								
Maternal GM								
Other								

Social History circle all that apply.

Marital Status: Single Divorced Separated Widowed/er

Married - spouse/years: _____ / _____

Children :

Employed / Retired – required activities: _____

Hobbies & Interests: _____

Important issues for physician to know: _____

How long is your drive to our office? _____ min.

Exposures and Habits

Tobacco Currently Smoke: Y / N Pipe? Y / N

Number of years smoked: _____

Average number of packs / day: _____

Year quit smoking: _____

Passive exposure (circle): Adult Child

Alcohol Currently Drink: Y / N

Average number of alcoholic drinks / week _____

Does alcohol affect your health, home or work? Y / N

Radiation Exposure? Yes / No

Asbestos Exposure? Yes / No

Other Risk Exposure? Yes / No

Explain: _____

Gynecologic History (women only)

Age at first menstrual period _____

Age at first pregnancy _____

Number of pregnancies _____

Number of live births _____

Menopause: Y / N / current

Age at menopause _____

Last menstrual period (date) ____/____/____

Is there any chance you could be pregnant: Y / N

Review of Symptoms

Circle all that apply

Constitutional

Fevers
Night sweats
Unintentional weight loss
Loss of appetite
Fatigue

Blood & Lymphatic

Swollen glands
Easy bleeding or bruising
Spontaneous bleeding from any site
Blood clots

Head & Neck

Visual changes
Ear problems
Dental problems
Sinus problems
Mouth or neck pain

Cardiac

Chest pain
Irregular heartbeat
Other heart problems

Respiratory

Cough
Shortness of breath
Coughing up blood
Coughing up colored sputum
Wheezing
Pain with breathing

Gastrointestinal

Mouth ulcers
Trouble swallowing
Nausea
Vomiting
Abdominal pain
Diarrhea
Constipation
Heartburn
Prior Colonoscopy
Number of BM's per day _____

Genitourinary

Trouble passing urine
Pain with urination
Urinary frequency
Night time urination
Urinary leakage
Menstrual problems
Sexual dysfunction

Neurologic

Numbness or tingling
Balance problems or vertigo
Speech problems
New or More Frequent Headaches
Severe Headaches
Nerve pain

Musculoskeletal

Weakness
Back or neck pain
Bone pain

Endocrinologic

Excessive thirst
Frequently too hot or cold

Dermatologic

Skin rash
Persistent itch

Psychiatric or Emotional

Depression
Loss of interest in usual activities
Sleeping problems

Notes and Other Symptoms
