RCCA
REGIONAL CANCER CARE ASSOCIATES LLC

PATIENT MEDICAL HISTORY FORM

Patient Name:_____ Date:_____ DOB:_____/_____/_____

Reason for this Visit: _____

_____

_____

_____

_____

Medical History: (Check the items that apply to you, currently or in the past.)

- ☐ None
- ☐ Anemia
- ☐ Bleeding Problem
- ☐ Blood Clots
- ☐ HIV / AIDS
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heartburn / Reflux
- ☐ Irregular Heart Beat
- ☐ Asthma
- ☐ Anxiety / Depression
- ☐ Chronic Lung (COPD)
- ☐ Pneumonia / Bronchitis
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Kidney Disease / Failure
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Cancer
- ☐ Leukemia
- ☐ Lymphoma

Other Medical History not listed above:

_____

_____

_____

_____

Patient Name:_____ Date:_____ DOB:_____/_____/_____

Have you ever experienced:

- ☐ Weight Loss – how much_____
- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue

Please list all surgeries you have had with approximate date:

_____

_____

_____

_____

_____

_____

_____

Social History:

Tobacco User:

- ☐ Never Smoked
- ☐ Quit Smoking When did you quit?_____How many years did you smoke?_____Yr(s)
- ☐ Currently Smoke: What age did you start?_____How many packs?___/day
- ☐ Chewing Tobacco: Yes_____ No_____ How often?_____

Other Drug Use:

- ☐ Marijuana: Yes_____ No_____ How often?_____
- ☐ Other: Name_____ Yes_____ No_____ How often?_____

Alcohol User: Present or Past

- ☐ Non-Drinker
- ☐ Drinker Current_____ Past_____ How many drinks per day?_____

Patient Name:_____ Date:_____ DOB:_____/_____/_____

Are you: ____Employed ___Unemployed ___Retired ___Disabled

(Former) Occupation: _____

Marital Status: ___Married ___Single ____Widowed _____Divorced Domestic Partner

___ Lives alone ___Lives with family

Children ___Yes ___No

Health Maintenance:

Sigmoidoscopy / Colonoscopy:	___ Yes	___ No	Date: _____	Location: _____
Mammogram:	___ Yes	___ No	Date: _____	Location: _____
Bone Density:	___ Yes	___ No	Date: _____	Location: _____
Pap Smear:	___ Yes	___ No	Date: _____	Location: _____
Influenza (Flu) Shot:	___ Yes	___ No	Date: _____	Location: _____
Pneumococcal Shot:	___ Yes	___ No	Date: _____	Location: _____

Hospitalization Information:

Date:	_____	Date:	_____
Description:	_____	Description:	_____
Why:	_____	Why:	_____
Where:	_____	Where:	_____
Date:	_____	Date:	_____
Description:	_____	Description:	_____
Why:	_____	Why:	_____
Where:	_____	Where:	_____

Family Medical History: (Indicate any family members with cancer, blood disease or other disease.)

	Age at Diagnosis	Disease	If deceased, cause of death_____
Father	_____	_____	
Mother	_____	_____	
Siblings	_____	_____	
Siblings	_____	_____	
	_____	_____	

Patient Name:_____ Date:_____ DOB:_____/_____/_____

Other

_____ _____ _____

_____ _____ _____

Drug Allergies: (List all medication allergies.)

_____

_____

_____

_____

Patient Name:_____ Date:_____ DOB:_____/_____/_____

Pharmacy / address / phone#: _____

_____

List all medications (including non-prescription) that you are currently taking:

Medication	**Dose**	**Frequency**

FEMALES ONLY

Number of Pregnancies___

Number of Miscarriages___

Pap Smear Date____

First Menstrual Period Age___

Age at first live birth___

Last Menstrual Period___

Oral Contraceptive Type ___

Hormone Replacement Therapy Yes___ No___

Patient Name:_____ Date:_____ DOB:_____/_____/_____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem or our patients whom we haven't seen for a while, we need to update our records as to your general medical health.

In each area noted below if you are not having any difficulties, please check "No Problems".

If you are experiencing any of the symptoms listed below, PLEASE CHECK THE ONES THAT APPLY or explain any that may not be listed. If you have any questions about this, please ask your doctor.

Patient Name:_____ Date:_____ DOB:____/____/_____

Constitutional (Health in General)	Ears, Nose, Mouth & Throat
☐ No problems ☐ Lack of energy ☐ Unexplained weight gain or weight loss ☐ Loss of appetite ☐ Fever ☐ Night sweats ☐ Pain in jaws when eating ☐ Scalp tenderness ☐ Prior diagnosis of cancer	☐ No problems ☐ Difficulty with hearing ☐ Sinus problems ☐ Runny nose ☐ Post-nasal drip ☐ Ringing in ears ☐ Mouth sores ☐ Loose teeth ☐ Ear pain ☐ Nosebleeds ☐ Sore throat ☐ Facial pain or numbness
Cardiovascular (Heart & Blood Vessels)	**Respiratory (Lungs & Breathing)**
☐ No problems ☐ Irregular heartbeat ☐ Racing heart ☐ Chest pains ☐ Swelling of feet or legs ☐ Pain in legs with walking ☐ Unable to sleep on a flat pillow	☐ No problems ☐ Shortness of breath ☐ Night sweats ☐ Prolonged cough ☐ Wheezing ☐ Sputum production ☐ Prior tuberculosis ☐ Pleurisy ☐ Oxygen at home ☐ Coughing up blood ☐ Abnormal chest x-ray or, imaging
Gastrointestinal (Stomach & Intestines) ☐ No problems ☐ Heartburn ☐ Constipation ☐ Intolerance to certain foods ☐ Diarrhea ☐ Abdominal pain ☐ Difficulty swallowing ☐ Nausea ☐ Vomiting ☐ Blood in stools ☐ Unexplained change in bowel habits ☐ Incontinence	**Genitourinary (Kidney & Bladder)** ☐ No problems ☐ Painful urination ☐ Frequent urination ☐ Urgency ☐ Prostate problems ☐ Bladder problems ☐ Impotence ☐ Blood in urine ☐ Kidney stones ☐ Change in stream when urinating ☐ Incontinence ☐ Dribbling ☐ Vaginal discharge (in female) ☐ Irregular periods (in female) ☐ Pain with periods (female)

Patient Name:_____ Date:_____ DOB:____/____/_____

Musculoskeletal (Muscles, Bones, Joints)	Integumentary (Skin, Hair)
☐ No problems ☐ Joint pain ☐ Aching muscles ☐ Shoulder pain ☐ Swelling of joints ☐ Joint deformities ☐ Back pain	☐ No problems ☐ Persistent rash ☐ Persistent itching ☐ New skin lesion ☐ Change in existing skin lesion ☐ Hair loss ☐ Excessive hair-growth
Breast ☐ No problems ☐ Lump ☐ Pain ☐ Discharge ☐ Breast changes	**Neurologic (Brain & Nerves)** ☐ No problems ☐ Frequent headaches ☐ Double vision ☐ Weakness ☐ Change in sensation ☐ Problems with walking or balance ☐ Dizziness ☐ Tremor ☐ Loss of consciousness ☐ Uncontrolled motions ☐ Episodes of visual loss ☐ Numbness or tingling sensations ☐ Paralysis
Psychiatric (Mood & Thinking) ☐ No problems ☐ Insomnia ☐ Irritability ☐ Depression ☐ Anxiety ☐ Recurrent bad thoughts ☐ Mood swings ☐ Hallucinations ☐ Compulsions	**Endocrinologic (Glands)** ☐ No problems ☐ Intolerance to heat or cold ☐ Menstrual irregularities ☐ Frequent hunger/urination/thirst ☐ Changes in sex drive ☐ Change is gloves or hat size ☐ Skin becoming dryer ☐ Diabetes ☐ Thyroid disease
Hematologic (Blood/Lymph) ☐ No problems ☐ Easy bleeding ☐ Easy bruising ☐ Anemia ☐ Abnormal blood tests ☐ Leukemia ☐ Unexplained swollen areas/glands ☐ Received transfusions	**Allergic/Immunology** ☐ No problems ☐ Seasonal allergies ☐ Sinus problems ☐ Hay fever symptoms ☐ Itching, ☐ Frequent infections ☐ Exposure to HIV ☐ Allergic to Penicillin ☐ Allergic to other antibiotics ☐ Allergic to narcotics (morphine, Demerol) ☐ Allergic to aspirin ☐ Allergic to Iodine ☐ Food allergies_____ _____ ☐ Other allergies_____ _____