Lancaster Cancer Center
Care Beyond Treatment

Patient Medical History

Patient Name: _____ Date: _____

Social History/Occupational History: Type & Amount How many years?

Do you use tobacco now? ❑ Yes ❑ No _____
Have you used tobacco in the past? ❑ Yes ❑ No _____
Do you use alcohol now? ❑ Yes ❑ No _____
Have you used alcohol in the past? ❑ Yes ❑ No _____
Do you use recreational drugs now? ❑ Yes ❑ No _____
Have you used recreational drugs in the past? ❑ Yes ❑ No _____

Marital Status? ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated
Do you live? ❑ Alone ❑ w/spouse ❑ w/children ❑ w/roommate ❑ other

Are you presently employed? ❑ Yes ❑ No ❑ Full-time ❑ Part-time
Most recent occupation: _____
Previous occupation(s): _____

Do you have a living will? ❑ Yes ❑ No

Screening History **Have you ever had a Blood Transfusion?** ❑ Yes ❑ No

Date of your last:
Pap Smear: _____
Breast exam: _____
Flu shot: _____
Pneumonia shot: _____
Mammogram: _____
Colonoscopy: _____
Dexascan: _____

OB/GYN

Age of first menstrual period: _____
Are your periods regular? ❑ Yes ❑ No
Date of last menstrual period: _____
Number of pregnancies: _____
Number of live births: _____
Menopause: ❑ Yes ❑ No
Onset date: _____
Have you ever taken Birth Control Pills? ❑ Yes ❑ No
Have you ever taken Hormone Replacement Therapy? ❑ Yes ❑ No

Past Medical History: Please circle if you have had problems with any of the following:

Abnormal Chest X-Ray
Abnormal EKG
Alzheimer's disease
Anemia
Angina
Anxiety disorder
Arthritis
Asthma
Bleeding disorder
Blindness
Blood Clot
Breast disease
Cancer
Type: _____
Carpal Tunnel Syndrome
Cataracts
Depression
Diabetes
Diarrhea
Diverticulitis
Ear infections
Fibroids
Gall bladder disease
Glaucoma
Goiter
Gout
Hay fever
Heartburn
Heart disease
Heart murmur
Hemorrhoids
Hepatitis
High blood pressure
High cholesterol
Hypoglycemia
Impotence
Irritable bowel syndrome
Kidney disease
Liver disease
Lung disease
Melanoma
Migraines/headaches
Multiple sclerosis
Osteoporosis
Panic Attacks
Phlebitis
Polio
Prostate enlargement
Raynauds
Schizophrenia
Seizures
Skin cancer
Stroke
Syphilis
Thyroid problem
Tuberculosis

Past Surgical History: Please list your past surgeries and dates:

_____
_____
_____
_____

Family History:

	Living	Age or Age @ death	List serious illnesses	If deceased: list cause of death
Mother	❑ Yes ❑ No	_____	_____	_____
Father	❑ Yes ❑ No	_____	_____	_____
Sisters	❑ Yes ❑ No	_____	_____	_____
Brothers	❑ Yes ❑ No	_____	_____	_____
Children	❑ Yes ❑ No	_____	_____	_____
		_____	_____	_____
		_____	_____	_____
		_____	_____	_____

Symptom Questionnaire

Constitutional

Recent weight loss	❑ Yes	❑ No
Recent weight gain	❑ Yes	❑ No
Fever/chills	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No
Night sweats	❑ Yes	❑ No
Appetite loss	❑ Yes	❑ No

Eyes

Blurred vision	❑ Yes	❑ No
Loss of vision	❑ Yes	❑ No
Pain or redness	❑ Yes	❑ No
Double vision	❑ Yes	❑ No

Ears/Nose/Mouth/Throat

Hearing loss	❑ Yes	❑ No
Ringing in ears	❑ Yes	❑ No
Nose bleeds	❑ Yes	❑ No
Runny nose	❑ Yes	❑ No
Sinus/Nasal congestion	❑ Yes	❑ No
Mouth sores	❑ Yes	❑ No
Bleeding gums	❑ Yes	❑ No
Sore throat	❑ Yes	❑ No

Cardiovascular

Chest pain	❑ Yes	❑ No
Palpitations	❑ Yes	❑ No
Shortness of breath	❑ Yes	❑ No
Swelling of ankles	❑ Yes	❑ No

Respiratory

Chronic cough	❑ Yes	❑ No
Spitting up blood	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No

Gastrointestinal

Difficulty swallowing	❑ Yes	❑ No
Heartburn/indigestion	❑ Yes	❑ No
Nausea/Vomiting	❑ Yes	❑ No
Stomach pain	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No

Genitourinary

Burning with urination	❑ Yes	❑ No
Blood in urine	❑ Yes	❑ No
Frequent urination	❑ Yes	❑ No
Difficulty urinating	❑ Yes	❑ No
Loss of bladder control	❑ Yes	❑ No
Night time urination	❑ Yes	❑ No

Musculoskeletal

Joint pain or swelling	❑ Yes	❑ No
Back pain	❑ Yes	❑ No
Muscle pain	❑ Yes	❑ No
Muscle weakness/twitching	❑ Yes	❑ No
Legs cramps	❑ Yes	❑ No

Neurological

Headaches	❑ Yes	❑ No
Dizziness/lightheadedness	❑ Yes	❑ No
Numbness/tingling	❑ Yes	❑ No
Problems with balance	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Speech problems	❑ Yes	❑ No

Pain

Site: _____

Medications: _____

_____

_____

Pain Level: 0,1 No pain_____

2,3 Mild pain _____

4,5 Moderate pain _____

6,7 Severe pain _____

8,9 Very Severe pain _____

10 Unbearable _____

Psychiatric

Memory loss	❑ Yes	❑ No
Confusion	❑ Yes	❑ No
Depression/feeling sad	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No
Difficulty sleeping	❑ Yes	❑ No

Constipation ❑ Yes ❑ No
Black stool ❑ Yes ❑ No
Rectal bleeding ❑ Yes ❑ No
Loss of bowel control ❑ Yes ❑ No
Change in caliber of stool ❑ Yes ❑ No

Hematologic

Easy bruising/bleeding ❑ Yes ❑ No
Swollen glands ❑ Yes ❑ No

Skin

Rash ❑ Yes ❑ No
Itching ❑ Yes ❑ No
Burning ❑ Yes ❑ No
Tumors ❑ Yes ❑ No

Medications

Please list all medications, including prescription, over the counter, vitamins, supplements and herbs.

Medication (example: Motrin)	**Dose** (ex. 200 mg)	**#of Times Per Day** (ex. 3 times a day)

Allergies

Please list below all drugs, foods, environmental, including latex powders, etc. that you have allergic reactions to along with the type of reaction.

Drug	Reaction