NEW PATIENT HISTORY FORM

NORTON CANCER INSTITUTE

Please fill out this form to the best of your knowledge so that your physician can get a better understanding of your current illness. Don't worry about spelling or exact dates. If you are uncomfortable writing something, please speak with your physician about it.

Personal history

Name: _____ Date of birth: _____/_____/_____ Age: _____

Today's date: _____ Social Security #: _____

Home phone: _____ Work phone: _____ Mobile phone: _____

Address: _____ City: _____ State/ZIP: _____

Emergency contact: _____ Relationship to you: _____

Home phone: _____ Work phone: _____ Mobile phone: _____

Primary doctor: _____ Address: _____

Referred by: _____ Address: _____

Other doctors you see regularly: _____ Address: _____

What is the reason for your visit today? _____

_____

Allergies: Are you allergic to latex? ❑ Yes ❑ No **List allergies to medications, food and other items:**

_____

_____

_____

Current medications (Name of medication)	**Dose** (Size in gm/mg/tsp, etc.)	**Times per day** (How often, a.m., p.m., etc.)

Preferred pharmacy: _____ **Phone:** _____

Current vitamins/herbal supplements (Name)	**Dose** (Size in gm/mg/tsp, etc.)	**Times per day** (How often, a.m., p.m., etc.)

Patient's name: _____

Past medical, surgical, trauma history					
List prior illness, serious injury, hospitalization, surgery (including C-sections), trauma and/or blood transfusion (plasma, hemophilia factor), including the hospital and date of admission.					
	Site on body	Start date	End date	Facility	Physician
Prior radiation treatment					
Prior chemotherapy					

Personal and family history (Mark those that apply and list the approximate age at the time of diagnosis)							
	You	Mother	Father	Sister	Brother	Children	Other (describe)
AIDS							
Alcoholism							
Alzheimer's disease							
Anemia							
Arthritis							
Asthma							
Bleeding disorder							
Breast cancer							
Colon cancer							
COPD (chronic obstructive pulmonary disease)							
Depression/anxiety							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart attack							
High blood pressure							
Irritable bowel syndrome							
Kidney disease							
Liver disease							
Mental illness							
Mental retardation							
Migraine headaches							
Miscarriages (3 or more)							
Pneumonia							
Prostate cancer							
Sickle cell anemia							
Skin cancer							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
_____cancer							
_____cancer							

Patient's name: _____

List the age of your mother, father, siblings and children if still living or age at time of death:

_____

_____

_____

List immunizations you have received and dates:

_____

_____

_____

Which childhood illnesses have you had: ❑ Rheumatic fever ❑ Mononucleosis ❑ Hepatitis ❑ Chickenpox ❑ Mumps ❑ Measles ❑ German measles ❑ Meningitis ❑ Tuberculosis

Social history

Where were you born? _____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Living arrangement: ❑ Alone ❑ Family ❑ Roommate ❑ Significant other

Companion's health: ❑ Fair ❑ Good ❑ Excellent

If you live alone, can someone assist you with your care after surgery? ❑ Yes ❑ No

Do you have difficulty with: ❑ Stairs ❑ Moving inside home ❑ Getting to the bathroom

Location of home: ❑ City ❑ Suburbs ❑ Rural/country ❑ No permanent residence

Do you have difficulty getting transportation to medical appointments? ❑ Yes ❑ No

Traveled outside of the U.S. in the past 5 years? ❑ Yes ❑ No If so, where: _____

Occupation: _____ Retired: ❑ Yes ❑ No If so, when: _____

Spouse's occupation: _____ Retired: ❑ Yes ❑ No If so, when: _____

Have you worked with harmful materials? ❑ Yes ❑ No If so, describe: _____

Do you smoke cigarettes? ❑ Yes ❑ No If yes, # years: _____ # packs per day: _____

Did you ever smoke? ❑ Yes ❑ No If yes, when did you quit? _____

Do you use smokeless tobacco products? ❑ Yes ❑ No If yes, which product? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, # drinks per week: _____

Have you ever had a problem with alcohol? ❑ Yes ❑ No Comments: _____

Do you drink caffeinated beverages? ❑ Yes ❑ No If yes, which? ❑ Coffee ❑ Tea ❑ Soft drinks

Do you use recreational drugs? ❑ Yes ❑ No If yes, what? _____

Do you have a special diet? ❑ Yes ❑ No If yes, why? _____

Do you use a seat belt? ❑ Yes ❑ No

Do you have pets? ❑ Yes ❑ No If yes, what types: _____

How many times per week do you exercise? _____ Sun exposure: ❑ Rarely ❑ Occasionally ❑ Frequently

What was your weight last year: _____ Now: _____ If a difference, why? _____

_____

Patient's name: _____

Health screening history (Please list date of last exam)

Colonoscopy: _____ Normal: ❑ Yes ❑ No

Chest X-ray: _____ Normal: ❑ Yes ❑ No

Rectal exam: _____ Normal: ❑ Yes ❑ No

Stress test/EKG: _____ Normal: ❑ Yes ❑ No

Fecal occult blood test: _____ Normal: ❑ Yes ❑ No

Other blood tests: _____ Normal: ❑ Yes ❑ No

Mammogram: _____ Normal: ❑ Yes ❑ No

Breast self-exam: _____ Normal: ❑ Yes ❑ No

Pap smear: _____ Normal: ❑ Yes ❑ No

Bone density: _____ Normal: ❑ Yes ❑ No

Review of systems (Mark any symptoms that you currently are experiencing)

Head		Eyes		Ears		Nose	
Frequent headaches		Recent change in vision		Loss of hearing		Frequent/persistent nosebleeds	
Severe headaches		Detached retina		Ringing in ears		Hay fever	
Light-headedness		Temporary vision loss		Ear discharge		Sinusitis	
Dizziness		Wear corrective lenses		Ear pain		Discharge from nose	
Loss of consciousness		Double/blurred vision					

Neck/throat		Respiratory		Heart		Digestive	
Persistent hoarseness		Persistent cough		Heart murmur		Gallbladder stones/attack	
Difficulty swallowing		Cough with sputum		Irregular heartbeat		Jaundice or hepatitis	
Large thyroid/goiter		Coughing up blood		Ankles/feet swelling		Diverticulitis	
Overactive thyroid		Short of breath		Shortness of breath walking		Vomiting blood	
Underactive thyroid		Exposure to TB		Shortness of breath at night		Recent change in appetite	
Enlarged lymph glands				Chest pain during exercise		Recent change in bowels	
Change in voice quality				Chest tightness		Dark black/"tarry" stools	
						Red blood in stools	
						Cramping/abdominal pain	
						Colitis/enteritis	
						Hemorrhoids	

Genitourinary		Skin		Breasts		Neurological	
Kidney stones/colic		Skin disorders		Lumps/nodules		Stroke/weakness of limbs	
Blood in urine		Changing moles		Changes in skin		Seizures	
Urine/kidney infection		Changing skin spots		Discharge from nipple		Epilepsy	
Protein/albumin in urine		Persistent itching				Loss of sensation in limbs	
Failing kidneys		Persistent skin pain				Loss of sensation in body	
Damaged kidneys		Recent change in skin					
History of dialysis		Recent change in hair					
Kidney transplant		Easy bruising					

Emotional		Miscellaneous	
Bipolar illness		Bleeding from dental treatments	
Sleeping problems		Increased or excessive thirst	
Receiving psychiatric care		Frequently too hot or cold	
Excessive worrying		Other problems (list below):	
Fears/phobias			
Crying spells			
Feelings of hopelessness			

Patient's name: _____

Men only

Prostate infection: ❑ Yes ❑ No Details:_____

Prostate surgery: ❑ Yes ❑ No Details:_____

Prostate exam (PSA): ❑ Yes ❑ No Details:_____

Difficulty urinating: ❑ Yes ❑ No Details:_____

Mass in testicles: ❑ Yes ❑ No Details:_____

Pain in testicles: ❑ Yes ❑ No Details:_____

Venereal diseases (VD): ❑ Yes ❑ No Details:_____

Sexual problems: ❑ Yes ❑ No Details:_____

Women only

Age at first menstruation: _____ Age at last menstruation: _____ Age at first pregnancy: _____

Total number of pregnancies: _____ Full-term births: _____ Premature births: _____

Number of children born: _____ Spontaneous miscarriages: _____ Elective abortions: _____

Could you be pregnant now? ❑ Yes ❑ No

Venereal diseases (VD): ❑ Yes ❑ No Details: _____

Sexual problems: ❑ Yes ❑ No Details: _____

Fertility treatments: ❑ Yes ❑ No Details: _____

Hormones used: ❑ Yes ❑ No Details: _____

Are your menstrual periods regular? ❑ Yes ❑ No Date of last menstruation: _____

Number of days period lasts: _____ Number of days between start of one period to start of next: _____

Menstrual flow: ❑ Heavy ❑ Medium ❑ Light What do you use? ❑ Pads ❑ Tampons

Method of contraception: ❑ Oral ❑ Condom ❑ Diaphragm ❑ Natural family planning ❑ Depo-Provera ❑ Partner sterilized ❑ IUD ❑ Implant ❑ Spermicide ❑ Rhythm birth control ❑ Tubal ligation ❑ None

Describe any complications during pregnancy or delivery:

_____

_____

_____