Oregon Oncology Specialists

PATIENT HISTORY

Today's Date: _____
Patient Name: _____
Date of Birth: _____
Age: _____
Referring Dr. _____
Primary Dr. _____
Ethnicity: _____
Language preferred: _____

Marital Status: ☐ Single ☐ Married
☐ Widowed ☐ Divorced ☐ Separated
Sex: ☐ Male ☐ Female

Current Height: _____
Normal weight: _____
Recent weight: _____

Chief Complaint: In your own words, what is your understanding of why you were referred here today?

PAST MEDICAL HISTORY

Have you ever had surgery or been hospitalized? ☐ Yes ☐ No If yes, please list below.

Please list prior surgeries or hospitalization with approximate dates (add additional pages if needed)

Date (Month/Year)	Reason

Have you ever been hospitalized for an accident? ☐ No ☐ Yes *Please list below.*
Year: _____ Result: _____
Year: _____ Result: _____

Have you had cancer previously? ☐ No ☐ Yes If yes, describe: _____

Have you had radiation? ☐ No ☐ Yes If yes, please list:
Area of Body: _____ Year (approximate): _____
Area of Body: _____ Year (approximate): _____

Have you ever had a blood transfusion? ☐ No ☐ Yes Most recent transfusion (date): _____
Did you have a reaction? ☐ No ☐ Yes

Have you had any of the following?
☐ Lupus ☐ fibromyalgia ☐ scleroderma ☐ pacemaker ☐ high blood pressure ☐ stroke ☐ heart disease
☐ asthma ☐ emphysema ☐ diabetes ☐ kidney disease ☐ arthritis ☐ ulcerative colitis
☐ liver disease/hepatitis ☐ rheumatoid arthritis ☐ kidney stones ☐ gallstones ☐ HIV
Other: _____

Comments:

MEN ONLY:

Difficulty getting or keeping erections? ☐ No ☐ Yes Prostate problems? ☐ No ☐ Yes
Last PSA? _____

WOMEN ONLY:

Pregnancies: #_____Children #_____Miscarriages #_____Abortions #_____

Age at first pregnancy:_____Still having menstrual cycles? ☐ No ☐ Yes If yes, ☐regular ☐irregular?

My last period was:_____ Is there a possibility you could be pregnant? ☐ No ☐ Yes

Last Pelvic or Pap exam?_____ Have you had spotting/bleeding between periods? ☐ No ☐ Yes

Vaginal bleeding, pain or discharge? ☐ No ☐ Yes Age at first period?_____Age at menopause? _____

Hormone replacement therapy? ☐ No ☐ Yes If yes, how long? Last Mammogram?

FAMILY HISTORY

My father is: alive at age_____dead at age_____Cause of death:_____
His health problems include:_____

He was born or lived in (check all that apply) ☐ Eastern Europe, ☐Asia, ☐Africa

My mother is: alive at age_____dead at age_____Cause of death:_____
Her health problems include: _____

She was born or lived in (check all that apply) ☐ Eastern Europe, ☐ Asia, ☐ Africa

I was born or lived in (check all that apply) ☐ Eastern Europe, ☐ Asia, ☐ Africa

I have/had _____brothers: # still living _____ # deceased _____
I have/had_____sisters: # still living _____ # deceased _____
I have/had Children: #Daughters_____#Sons_____#still living_____#deceased_____
Health problems, especially cancer, that run in the family: _____

SOCIAL HISTORY

Employment:

I currently ☐ do not work ☐ work as: _____
I previously ☐ did not work ☐ work as: _____
Does/did your work expose you to chemicals? ☐ No ☐ Yes If yes, specify:_____

Current Living Arrangements: City of residence:_____

☐ Live alone ☐ With spouse/significant other ☐ With family ☐ With a friend(s) ☐ Other _____

Do you have concerns you would like to discuss concerning:

☐ Transportation ☐ Home care assistance ☐ Health care expense ☐ Support groups or counseling

HABITS

Tobacco

Do you currently use tobacco? ☐ No ☐ Yes Packs per day:_____

Have you used it in the past? ☐ No ☐ Yes How long?_____years
If yes, please describe ☐ cigarettes ☐ cigars ☐ chewing tobacco

If stopped, when?_____Are you interested in a tobacco cessation program? ☐ No ☐ Yes

Alcohol: Do you drink alcohol? ☐No ☐Yes If yes, number of drinks:_____per ☐day/☐week/☐month

Caffeine: Do you use products containing caffeine? ☐ No ☐ Yes Amount per day _____

Drug exposure: I have used "recreational" drugs in the past/currently ☐ No ☐ Yes
I have a history of intravenous (IV) drug use ☐ No ☐ Yes

Exercise: Do you exercise? ☐ regularly ☐ seldom ☐ never
What type: _____

MEDICATIONS: (attach list if more room needed)

Drug	Dose	Frequency	Drug	Dose	Frequency

Do you use health food supplements? ☐ No ☐ Yes

Please list: _____

Are you allergic to any medications, foods or tape? ☐ No ☐ Yes If yes, list below

Medication, Food, Tape	Reaction:	Medication, Food, Tape	Reaction:

REVIEW of SYSTEMS

Do you currently have any of the following:

☐No ☐Yes	**Autoimmune:** Lupus , fibromyalgia or scleroderma; other: _____
☐No ☐Yes	**Constitutional:** Weight loss, night sweats, fevers, loss of appetite, fatigue or other problems
☐No ☐Yes	**Eye, Ear, Nose, Throat:** Glaucoma, cataracts, double vision, blurred vision, wear contacts, lens implant(s) or artificial eye, hoarseness, dentures, ear pain, sore throat, painful swallowing, difficulty swallowing
☐No ☐Yes	**Heart:** Chest pain, angina, heart attack, heart failure, irregular heartbeats, pacemaker, ankle swelling, nighttime shortness of breath, racing heart
☐No ☐Yes	**Vascular:** Blood clots, leg cramps when walking, elevated cholesterol
☐No ☐Yes	**Lung:** Tuberculosis, coughing, coughing up blood, shortness of breath at rest or with activity
☐No ☐Yes	**Endocrine:** Thyroid disease, other: _____
☐No ☐Yes	**Gastrointestinal:** Cirrhosis, ulcers, hiatal hernia, intestinal bleeding, nausea, vomiting, constipation, diarrhea, diverticulitis, colitis, irritable bowel syndrome (IBS), celiac disease, GERD ☐ Colonoscopy Date: ☐Upper Endoscopy Date:_
☐No ☐Yes	**Genitourinary**: Pain on urination, incontinence, blood in the urine, night time urination, frequency of daytime urination, unable to control urine or need to wear a pad
☐No ☐Yes	**Musculoskeletal:** Back problems, broken bones of neck/back/face, limited range of motion, arthritis, pain in bones, difficulty lying flat for prolonged periods, joints or muscles, scleroderma, dermatomyositis
☐No ☐Yes	**Skin:** Rash, hives, open sores
☐No ☐Yes	**Neurological:** Seizures, paralysis/numb areas, stroke, weakness, migraines, confusion, memory loss, headaches
☐No ☐Yes	**Psychosocial:** Anxiety, depression, bipolar disorder, claustrophobia, PTSD
☐No ☐Yes	**Previous Cancer:** _____

Other:

NOTES: Have you checked with your insurance company regarding pre-authorization?

Reminder: If anything changes regarding your insurance coverage, we will need to know.