Oregon Oncology Specialists

PATIENT HISTORY FORM

Today's Date: _____
Patient Name: _____
Date of Birth: _____
Age: _____
Referring Dr. _____
Primary Care Provider: _____
Ethnicity: _____
Language preferred: _____
Are you in need of a translator? _____

Marital Status: ☐Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Gender: ☐ Male ☐ Female ☐ non-Binary ☐ Other _____

Pronouns: _____

Height: _____
Weight: _____

Chief Complaint: What is your understanding of why you are being seen here today?

PAST MEDICAL HISTORY

Have you been treated for cancer in the past? ☐ **No** ☐ **Yes** **If yes, describe:** _____

Have you been treated with radiation? ☐ **No** ☐ **Yes** **If yes, please list below:**
Area of Body: _____ **Year (approximate):** _____
Area of Body: _____ **Year (approximate):** _____

Have you ever had a blood transfusion? ☐ **No** ☐ **Yes**

Have you ever had a transfusion reaction or allergic reaction to blood products? ☐ **No** ☐ **Yes**

Have you ever had surgery? ☐ No ☐ Yes, please list below:

Date (Month/Year)	Procedure	Date (Month/Year)	Procedure

REPRODUCTIVE HEALTH

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

Age at first period _____ **Still having menstrual cycles?** ☐ No ☐ Yes

Age at first pregnancy: _____ **Is there a possibility you could be pregnant?** ☐ No ☐ Yes

Pregnancies: #_____Children #_____Miscarriages #_____Abortions #_____

Age at menopause? _____**Hormone replacement therapy?** ☐ No ☐ Yes

Contraception (if of childbearing potential): ☐ No ☐ Yes What type: _____

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FAMILY HISTORY

My father is: alive at age_____death at age_____Cause of death_____

My mother is: alive at age_____death at age_____Cause of death _____

I have/had _____brothers. # brothers still living _____ # brothers deceased _____
I have/had_____sisters. # sisters still living _____ # sisters deceased _____

I have/had children: #Daughters_____#Sons_____#still living_____#deceased_____

Health problems that run in the family: _____

Family history of cancer

Relationship to you (patient)	Maternal (mother's side)	Paternal (father's side)	Cancer site/ type of cancer	Age at diagnosis	Comment
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			

SOCIAL HISTORY

Employment:

I currently ☐ am not employed ☐ employed as: _____
I previously ☐ was not employed ☐ worked as: _____

Does/did your work expose you to chemicals? ☐ No ☐ Yes If yes, what chemicals?_____

Veteran Status: Are you a veteran? ☐ No ☐ Yes **Branch of military:** _____

Did you serve in combat? ☐ No ☐ Yes **Were you exposed to Agent Orange or asbestos?** ☐ No ☐ Yes

Current Living Arrangements: ☐ Live alone ☐ With spouse/significant other ☐ With family ☐ With a friend(s)

Other:_____

HABITS

Tobacco: Do you use tobacco products? □ No □ Yes □ cigarettes □ cigars □ chewing tobacco □ vaping
How many packs/ times per day? _____ How long? _____
Have you used tobacco in the past? □ No □ Yes If stopped, when? _____

Alcohol: Do you drink alcohol? □ No □ Yes- number of drinks:_____per □ day/□ week/□ month
Did you drink heavily in the past? □ No □ Yes

Drug use: Do you use drugs? □ No □ Yes- what type/ how often? _____
Do you use marijuana? □ No □ Yes □ edibles □ oils/ tinctures □ inhalants
Do you have a history of drug use in the past? □ No □ Yes _____

MEDICATIONS:

Name of Drug	Dose	Frequency	Name of Drug	Dose	Frequency

ALLERGIES:

Are you allergic to any medications, vaccines, contrast dye, latex, or adhesives? ☐ No ☐ Yes

Please List: _____

Preferred Pharmacy: _____

Vitamin, Supplement Name	Dose	Frequency	I am taking for:

MEDICAL CONDITIONS (PAST or PRESENT): CIRCLE ALL THAT APPLY:

Autoimmune: Lupus, fibromyalgia, scleroderma, HIV, dermatomyositis, RA, Crohn's

Constitutional: Weight loss, night sweats, fevers, loss of appetite, fatigue, or other problems

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

Heart: Chest pain, angina, heart attack, heart failure, irregular heartbeats, palpitations, high blood pressure, pacemaker, ankle swelling, nighttime shortness of breath

Vascular: Blood clots, stroke, leg cramps when walking, elevated cholesterol

Lung: Asthma, emphysema, tuberculosis, coughing, coughing up blood, shortness of breath at rest or with activity

Endocrine: Diabetes (type I, II), Thyroid disease, other:_____

Gastrointestinal: Cirrhosis, ulcers, hiatal hernia, intestinal bleeding, nausea, vomiting, constipation, diarrhea, diverticulitis, colitis, irritable bowel syndrome (IBS), celiac disease, GERD, hepatitis A, hepatitis B, hepatitis C

Genitourinary: Pain on urination, incontinence, blood in the urine, nighttime urination, increased frequency of urination, unable to control urine or need to wear a pad

Musculoskeletal: Back problems, limited range of motion, arthritis, pain in bones, difficulty lying flat for prolonged periods, joints, or muscles

Skin: Rash, hives, open sores, non-healing wounds

Neurological: Seizures, paralysis/numb areas, stroke, weakness, migraines, confusion, memory loss, headaches
Psychosocial: Anxiety, depression, bipolar disorder, claustrophobia, PTSD
Other:

PERFORMANCE STATUS:

GRADE	ECOG PERFORMANCE STATUS: Please circle the grade that most closely reflects your current activity level
0	**Fully active, able to carry on all pre-disease performance without restriction**
1	**Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work**
2	**Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours**
3	**Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours**
4	**Completely disabled; cannot carry on any selfcare; totally confined to bed or chair**

ONCOLOGY PATIENTS ONLY:

1. **I would like to speak with someone to help me cope with my cancer diagnosis.** ☐ No ☐ Yes
2. **I would like to speak with someone about my worries over money, transportation, or community resources.** ☐ No ☐ Yes
3. **I would like to speak with someone for more spiritual support.** ☐ No ☐ Yes
4. **I am interested in learning more about support groups.** ☐ No ☐ Yes
5. **I am interested in learning more about a peer navigator.** ☐ No ☐ Yes

If you answered "yes" to any of the above questions, a referral may be made for Community Cancer Resources.

Is there anything else you would like your doctor to know?

_____

_____