Oregon Oncology Specialists
A Practice of Oregon Specialty Group

Patient History Form

Today's Date: _____
Patient Name: _____
Date of Birth: _____
Age:
Referring Provider: _____
Primary Care Provider: _____
Language Preferred: _____
Are you in need of a translator? ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Gender: ☐ Male ☐ Female ☐ Non-Binary
Other: _____
Preferred 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, what kind? _____
Have you been treated for radiation? ☐ No ☐ Yes - If yes, complete below:
Area of the body: _____ Approximate Year: _____
Area of the body: _____ Approximate Year: _____ Have you had a blood transfusion: ☐ No ☐ Yes
Have you ever had a transfusion rection or allergic reaction to blood products? ☐ No ☐ Yes Have you ever had a surgery? ☐ No ☐ Yes - If yes, complete below

Month/Year	Procedure	Month/Year	Procedure

REPRODUCTIVE HEALTH

Difficulty getting or keeping erections? ☐ No ☐ Yes Prostate problems? ☐ No ☐ Yes
Age at first period: _____ Are you still having menstrual cycles? ☐ No ☐ Yes
Age at first pregnancy: _____ Is there a possibility you are pregnant? ☐ No ☐ Yes
Number of pregnancies: ___ Children #: _____ Miscarriages #: _____ Abortions #: _____
Age at menopause: _____ Hormone replacement therapy? ☐ No ☐ Yes
Contraception: ☐ No ☐ Yes

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: _____

Number of brothers: ____ Number of brothers still living: ____

Number of sisters: ____ Number of sisters still living: ____

Number of children: ____ Daughters #: ____ Sons #: ____ Still living #: ____

Please list health problems that run in your family: _____

_____

Family History of Cancer in Relationship to Patient

Relationship to you	Mother's side	Father's side	Cancer Site/Type	Age at diagnosis

SOCIAL HISTORY

Employment:

Currently Employed: ☐ No ☐ Yes, employed at:_____

Previously worked as: _____

Does/Did your work expose you to chemicals? ☐ No ☐ Yes – list chemicals: _____

Are you a veteran? ☐ No ☐ Yes What branch of military? _____

Did you serve in combat? ☐ No ☐ Yes

Were you exposed to Agent Orange or asbestos? ☐ No ☐ Yes

Currently Living: ☐ Alone ☐ With spouse/partner ☐ With family ☐ With friends

Other: _____

HABITS

Do you use tobacco products? ☐ No ☐ Yes – ☐ Cigarettes ☐ Chewing tobacco ☐ Other: _____

How many times per day? _____ Have you used tobacco in the past? ☐ No ☐ Yes

If stopped, when? _____

Do you drink alcohol? ☐ No ☐ Yes - Number of drinks: _____per ____day ____week _____month

Did you drink heavily in the past? ☐ No ☐ Yes

Do you use illicit drugs? ☐ No ☐ Yes - What Type/How often? _____

Do you use marijuana? ☐ No ☐ Yes – How do you use marijuana? ☐ Edibles ☐ Oils/Tinctures ☐ Inhalants

Do you have a history of drug use? ☐ No ☐ Yes – explain below:

_____

_____

MEDICATIONS

Name of Drug	Dose	Frequency	Name of Drug	Dose	Frequency

Preferred Pharmacy: _____

Allergies:

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

If yes, please list: _____

VITAMINS & SUPPLEMENTS

Vitamin or Supplement Name	Dose	Frequency	I am taking for:

PERFORMANCE STATUS: Please check the grade that reflects your current activity level

Grade	ECOG Performance Status
☐ 0	Fully active, able to carry on all pre-disease performance without restriction
☐ 1	Restricted in physically strenuous activity but ambulatory and able to perform light duty to sedentary tasks; 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 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

I would like to speak with someone to help cope with my cancer	☐ Yes ☐ No
I would like to speak with someone about my worries over money, transportation, or community resources	☐ Yes ☐ No
I would like to speak to someone for more spiritual support	☐ Yes ☐ No
I am interested in learning more about support groups	☐ Yes ☐ No
I am interested in learning more about peer navigator	☐ Yes ☐ No

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 be aware of? _____

_____

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PAST AND PRESENT MEDICAL CONDITIONS: Check all that apply

Autoimmune:
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Scleroderma
- ☐ HIV
- ☐ Dermatomyositis
- ☐ Rheumatoid Arthritis
- ☐ Crohn's Disease

Constitutional:
- ☐ Weight Loss
- ☐ Night Sweats
- ☐ Fevers
- ☐ Loss of Appetite
- ☐ Fatigue

Eyes, Ears, Nose, Throat:
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Double Vision
- ☐ Blurred Vision
- ☐ Wear Contacts
- ☐ Lens Implant(s)
- ☐ Artificial Eye
- ☐ Hoarseness
- ☐ Dentures
- ☐ Ear Pain
- ☐ Sore Throat
- ☐ Painful and/or Difficulty Swallowing

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disease

Neurological:
- ☐ Seizures
- ☐ Paralysis and/or Numb areas
- ☐ Stroke
- ☐ Weakness
- ☐ Migraines
- ☐ Confusion
- ☐ Memory Loss
- ☐ Headaches

Psychosocial:
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Claustrophobia
- ☐ PTSD

Heart:
- ☐ Chest Pain
- ☐ Angina
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Irregular Heartbeat
- ☐ Palpations
- ☐ 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 of with activity

Musculoskeletal:
- ☐ Back Problems
- ☐ Limited range of motions
- ☐ Arthritis
- ☐ Pain in Bones
- ☐ Difficulty breathing, lying flat or for prolonged periods
- ☐ Pain in joints or muscles

Skin:
- ☐ Rash
- ☐ Hives
- ☐ Open sores
- ☐ Non-healing wounds

Genitourinary:
- ☐ Pain with urination
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Nighttime urination
- ☐ Increased frequency of urination
- ☐ Unable to control urine or need to wear a pad

Gastrointestinal:
- ☐ Cirrhosis
- ☐ Ulcers
- ☐ Hiatal hernia
- ☐ Intestinal Bleeding
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Celiac Disease
- ☐ GERD
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Other:

_____
_____
_____
_____
_____
_____
_____