

# Cancer Care Associates, Medical Oncology

Today's Date: \_\_\_\_\_

(Please Print)

What do you consider to be your chief health problems at this time?

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## Past Medical Illness

- Have you ever:
- had any form of cancer?
  - been treated for any serious illness or injury?
  - been hospitalized for surgery or illness?
  - had any chronic or recurrent disorder diagnosed?

Illness, injury, surgery

Facility where treated

Date

Illness, injury, surgery	Facility where treated	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you are presently under a physician's care for any disorder, please explain:

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Do you use any medications regularly?  Yes  No If yes, please list type & frequency of use:

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Are you allergic to: Penicillin  Yes  No  
Iodine  Yes  No  
Other: \_\_\_\_\_

Within the past 2 (two) years have you had:

- Electrocardiogram (EKG)  Yes  No
- GI Series  Yes  No
- Gall Bladder Series  Yes  No
- Barium Enema  Yes  No
- Kidney X-rays (IVP)  Yes  No
- Chest X-Ray  Yes  No
- Other Medical Testing: \_\_\_\_\_

Do you have more than an average of 15 alcoholic drinks per week?  Yes  No  
If yes, how many? Liquor \_\_\_\_\_, Beer \_\_\_\_\_, Wine \_\_\_\_\_

Do you work close to cleaning fluids, paints, dyes, Benzene liquids?  Yes  No

Do you have unusual occupational or personal stress  Yes  No

Please explain: \_\_\_\_\_

Do you or did you smoke? Cigarettes  Yes  No  
How many packs per day? \_\_\_\_\_  
For how long? \_\_\_\_\_  
Cigars  Yes  No  
Pipes  Yes  No  
Have you stopped smoking?  Yes  No  
How long ago? \_\_\_\_\_

Do you or have you worked with: Radioactive material  Yes  No  
Asbestos, stone, coal or other mineral dust  Yes  No

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(Please Print)

**Has a member of your family (not related by marriage) ever had any of the following diseases?  
If yes, state relationship to you:**

Cancer: \_\_\_\_\_  
Diabetes: \_\_\_\_\_  
Tuberculosis: \_\_\_\_\_  
High blood pressure: \_\_\_\_\_  
Heart disease: \_\_\_\_\_

Stroke: \_\_\_\_\_  
Polyps of colon: \_\_\_\_\_  
Thyroid disorder: \_\_\_\_\_  
Chronic kidney disease: \_\_\_\_\_

## Review of Systems

Please check "yes" or "no" next to the symptom listed below and use the line following the question to explain; including duration of symptom.

### General & Cutaneous

Unexplained persistent and generalized itching: \_\_\_\_\_  Yes  No  
Night sweats: \_\_\_\_\_  Yes  No  
Unexplained fever: \_\_\_\_\_  Yes  No  
Persistent swelling of any glands: \_\_\_\_\_  Yes  No  
Any moles or skin lesions which have changed color in size, ulcerated or bled: \_\_\_\_\_  Yes  No

Recent unexplained change in weight and appetite: \_\_\_\_\_  Yes  No  
Recent unexplained change in tolerance to hot or cold: \_\_\_\_\_  Yes  No

### Head & Neck

Hoarseness: \_\_\_\_\_  Yes  No  
Pain on swallowing: \_\_\_\_\_  Yes  No  
Persistent sore throat: \_\_\_\_\_  Yes  No  
Recurrent nose bleeds: \_\_\_\_\_  Yes  No

### Cardio Respiratory & Vascular

Chronic Cough: \_\_\_\_\_  Yes  No  
With production of sputum: \_\_\_\_\_  Yes  No  
With blood streaked sputum: \_\_\_\_\_  Yes  No  
Is it worse in the morning? \_\_\_\_\_  Yes  No  
Persistent wheezing: \_\_\_\_\_  Yes  No  
Shortness of breath : \_\_\_\_\_  Yes  No  
Persistent chest pain: \_\_\_\_\_  Yes  No  
Swelling of the ankles: \_\_\_\_\_  Yes  No  
Repeated episodes of phlebitis (inflammation of veins): \_\_\_\_\_  Yes  No

### Gastrointestinal

Troublesome indigestion, abdominal pain, nausea: \_\_\_\_\_  Yes  No  
Persistent fullness on the upper abdomen: \_\_\_\_\_  Yes  No  
Vomiting of blood: \_\_\_\_\_  Yes  No  
Recent onset of constipation or diarrhea: \_\_\_\_\_  Yes  No  
Increased narrowness of stool: \_\_\_\_\_  Yes  No  
Pain in the rectum: \_\_\_\_\_  Yes  No  
Blood in the stool or tar-colored stool: \_\_\_\_\_  Yes  No  
Large amounts of mucus with bowel movements: \_\_\_\_\_  Yes  No

### Urinary Tract

Frequency of urination: How often during day? \_\_\_\_\_ Night? \_\_\_\_\_  
Pain on Urination: \_\_\_\_\_  Yes  No  
Blood in urine: \_\_\_\_\_  Yes  No

