HOPE CANCER CLINIC NEW PATIENT HISTORY FORM PAGE 1 OF 2

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Original Date:	01-05-2009
Dates Revised:	

ALL QUESTIONS ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD.

Name *(Last, First, M.I.)*:	☐ M ☐ F	DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Occupation: ☐ Retired ☐ Homemaker ☐ working. Describe your job:		
CURRENT MEDICATIONS: If you have a copy of list check here ☐ and give us a copy and leave the list below blank.		
Name the Drug (List all of your medications)	Name the Drug (List all of your medications)	Over the counter medications
1.	6.	1.
2.	7.	2.
3.	8.	3.
4.	9.	4.
5.	10.	5.
ALLERGIES TO MEDICATIONS:		☐ NO KNOWN DRUG ALLERGIES
☐ KNOWN DRUG ALLERGIES: List drug and reaction. ☐ PENICILLIN	☐ SULFA	☐ OTHER:

PAST MEDICAL HISTORY: CHECK APPROPRIATE BOX FOR ANY PRIOR MEDICAL PROBELMS	
Heart problems	☐ Heart attack. ☐ Heart failure. ☐ Atrial fibrillation. ☐ Irregular rhythm. ☐ stent-angioplasty. ☐ Coronary bypass. ☐ Other.
Lung problems	☐ COPD. ☐ Emphysema. ☐ Lung cancer. ☐ Hard of breathing. ☐ Blood clots in lungs. ☐ Pneumonia. ☐ Other.
GI problems	☐ Acid reflux. ☐ Stomach ulcer. ☐ Diverticulosis. ☐ irritable bowel syndrome. ☐ EGD. ☐ Colonoscopy. ☐ other .
GU problems	☐ Enlarged prostate. ☐ Incontinence. ☐ Bladder infection. ☐ kidney failure. ☐ Kidney stone. ☐ other
Endocrine	☐ Hypertension. ☐ Diabetes mellitus. ☐ Thyroid problems. ☐ Other.
Neurological	☐ Stroke. ☐ TIA-mini stroke. ☐ Neuropathy. ☐ Paralysis. ☐ Migraines. ☐ vertigo. ☐ Other.
Vascular	☐ Blood clots in legs. ☐ Poor circulation. ☐ Carotid blockade. ☐ Carotid surgery. ☐ Other.
Skeletal	☐ Arthritis. ☐ Fracture. ☐ Spinal stenosis. ☐ Back surgery. ☐ Back injections. ☐ Joint replacement. ☐ other
Psychiatry	☐ Depression. ☐ Anxiety. ☐ Panic disorder. ☐ other.
Skin	☐ Melanoma. ☐ Non- melanoma skin cancer. ☐ Benign moles ☐ skin rash. ☐ Other .
Blood	☐ Anemia. ☐ Low white cells ☐ low platelets. ☐ prior transfusions . ☐ other .
Surgeries	☐ Appendix. ☐ Hernia. ☐ Gall bladder. ☐ Other.
Cancer	☐ Prior cancer history-if yes provide details. ☐ Breast. ☐ Lung. ☐ Colon. ☐ other
Other	Height: _____ft ______in_. Weight: __________ lbs.

SYMPTOM REVIEW: check appropriate box for any symptoms you are experiencing.	
General	☐ Fever. ☐ Low appetite. ☐ Weight loss. ☐ Tiredness. ☐ Fatigue. ☐ Night sweats. ☐ Other.
Cardiac	☐ Chest pain. ☐ Palpitations. ☐ Angina. ☐ Dizziness. ☐ Other.
Respiratory	☐ Cough. ☐ Short of breath. ☐ Sputum. ☐ Blood in sputum. ☐ other
GI	☐ Heartburn. ☐ Abdominal pain. ☐ Nausea-vomiting. ☐ Diarrhea. ☐ Constipation. ☐ Blood in stool. ☐ Other.
GU	☐ Frequent urination. ☐. Urinary pain. ☐ Incontinence. ☐ difficulty in urination . ☐ blood in urine . ☐ other .
Hem-onc	☐ Skin bleeding. ☐ Gum bleeding. ☐ Other.
Neurological	☐ Headaches. ☐ Dizziness. ☐ Weakness in arms or legs. ☐ Seizures. ☐ Imbalance. ☐ other

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Extremities	☐ Leg pains. ☐ Swollen legs. ☐ Numbness. ☐ Tingling. ☐ other
Skeletal	☐ Back pain. ☐ Hip pain. ☐ Knee pain. ☐ Other bone pain. ☐ Muscle pain. ☐ Muscle spasms. ☐ other
Psychiatry	☐ Feel depressed. ☐ Feel anxious. ☐ Lack of sleep. ☐ Other.
Skin	☐ Skin itching. ☐ Skin rash. ☐ other
Eyes	☐ Poor vision. ☐ Double vision. ☐ Cataracts. ☐ Glaucoma. ☐ Glasses. ☐ other
Ears:	☐ Hard of hearing. ☐ Ringing in ears. ☐ Hearing aids. ☐ Other.
Oral cavity	☐ Mouth sores. ☐ Swallowing problems. ☐ Dental problems. ☐ Jaw pain. ☐ Other .
Other: Describe any other symptoms not listed above.	

HEALTH HABITS AND PERSONAL SAFETY

Personal Safety	Do you live alone? ☐ Yes. ☐ No. Do you have frequent falls? ☐ Yes. ☐ No.			
Alcohol	Do you drink alcohol? ☐ Yes. ☐ No. If yes, what kind? How many drinks per week?			
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ _____# of years	☐ Or year quit _________ .		
Advanced directives: Do you have an Advance Directive or Living Will? ☐ Yes. ☐ No. ☐ Check here if Need more information on these.				

FAMILY HEALTH HISTORY

☐ NO KNOWN FAMILY HISTORY OF CANCER

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		OTHER:		
	☐ M ☐ F				

WOMEN ONLY

Age at onset of menstruation: ____________.	☐ Active menstruation.	Date of last menstruation: _____________.
☐Menopausal. Year of menopause: __________,	☐ Any hot flashes.	☐ Any hormonal replacement therapy
Number of pregnancies ______.	Number of live births ______.	Age at first pregnancy_________
☐ D& C. ☐ Tubal ligation	☐ Hysterectomy.	☐ Ovarian surgery.
Date of last pap and pelvic exam: ________________________.	Performed by Dr. ___________________________________.	
Date of last mammogram: ________________________.	☐ I perform self breast exam.	☐ I get regular mammograms.
Other:		

Information I provided above is true to my knowledge. .

Form completed by ☐ patient or ☐ relative or ☐ friend or ☐other ________________________________

Signature of the patient: ____ Date: ________________________