Patient Name _____

Date of Birth _____

Thank you for choosing Southern Cancer Center for your care. To help us best prepare for your appointment, please complete this form and bring it to your appointment. If you have questions, please call us at 251-625-6896.

Health Questionnaire

PHYSICIAN AND PHARMACY INFORMATION

Physician who **referred** you to this visit_____ **or** □ Self referred

Primary Care Physician:

_____ _____
Name Specialty

_____ (_____)_____
City State Telephone

Specialty physician (Surgeon, Ob/Gyn, Oncologist, Cardiologist, other):

_____ _____
Name Specialty

_____ _____
Name Specialty

Pharmacy: For most of our pharmacy needs, we use:

_____
Name of Pharmacy

_____ (_____)_____
Address Telephone

_____
City State Zip

Patient Name _____

Date of Birth _____

MEDICAL HISTORY

Please list: 1) Current medical problems, prior medical illnesses/hospitalizations
2) Prior surgeries, procedures, recent scans/test

Date	Description	Physician/Medical Facility

Have you ever been diagnosed with cancer? If yes did you receive chemotherapy? □ Yes □ No

Describe the situation: _____

Have you ever received radiation? □ Yes □ No

Describe the situation: _____

Have **you** had any of the following illnesses? If so, please mark with an X:

□ High blood pressure
□ Diabetes
□ Heart attack
□ Congestive heart failure
□ Heart murmur
□ Stroke
□ Liver disease
□ Hepatitis
□ Kidney disease
□ Thyroid disease
□ Autoimmune/connective tissue disease (lupus, scleroderma etc.)
□ HIV/AIDS
□ Asthma/COPD
□ Tuberculosis
□ Sleep apnea
□ Reflux/GERD
□ Depression
□ Anxiety
□ Arthritis
□ Easy bleeding
□ Blood clots
□ Anemia
□ Atrial Fibrillation
□ Pacemaker
□ Other_____
□ _____
□ _____
□ _____
□ _____

Patient Name _____

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Medications

Please list all medications you are currently taking, including those you buy without a doctor's prescription.

Name	Dose	Directions/Number per day

Do you currently take oral iron supplements? Yes or No

Allergies and Sensitivities

Are you allergic to or have you had a bad reaction to any medicine or other substance? If, so please describe. *If you have a history of penicillin allergy, please note date of onset, reaction, and whether you have been able to take Keflex, Amoxicillin, Augmentin afterwards.*

Allergic to:	Reaction:

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Health Maintenance: Please list the date of last exam and, if abnormal, any findings if known.

- Last mammogram: ____/____/____ Location: _____
- Last colonoscopy: ____/____/____ Location: _____
- Last bone density scan: ____/____/____ Location: _____
- Last Echocardiogram: ____/____/____ Location: _____
- Shingles vaccine: ____/____/____
- Influenza vaccine ____/____/____
- Pneumovax vaccine ____/____/____

FAMILY HISTORY

Please check below if any blood relative has had any of the following conditions and note **which relatives** (**and whether on maternal/paternal side**) are affected.

□ Diabetes
□ Heart attack
□ Stroke
□ Kidney disease
□ Thyroid disease
□ Autoimmune disease
□ Easy bleeding
□ Blood clots

Cancer Which type:_____ Relationship to you:_____ Age diagnosed:_____

Cancer Which type:_____ Relationship to you:_____ Age diagnosed:_____

Is there a history of the following cancers (circle):

Breast / Ovarian / Uterine / Colon / Prostate / Pancreatic / Melanoma

Patient Name _____

Date of Birth _____

PERSONAL HISTORY

Currently live: □ Alone □ With family □ With significant other □ With friends

Marital status: □ Married □ Separated □Divorced □ Widowed □ Never married

Occupation:_____

Do you have children? □ Yes □ No Ages: _____

Do you smoke or chew tobacco? □ Yes □ No Cigarettes per day:_____ Packs per week: _____

Duration of habit (yrs)_____

How would you describe your use of alcohol?_____

Amount per week of: Beer_____ Wine_____ Liquor_____

Do you now, or have you in the past, used drugs? □ Yes □ No Type: _____

Do you have an Advanced Directive (Living Will, Durable Power of Attorney)? □ Yes □ No

REVIEW OF SYSTEMS

Please circle any of the following which apply to you.

Category	Issues	No Problems
General	Appetite change, fatigue, fevers, sweats, weight loss, weight gain, weakness	□
Skin	Itching, rash, mole change	□
Eyes	Vision change, cataracts, glaucoma	□
Ears/Nose/Mouth	Dizziness, ringing in the ears, sore throat, hoarseness	□
Lungs	Cough, chest pain, shortness of breath, wheezing, coughing blood	□
Heart	Chest pain, shortness of breath with exertion, palpitations, fainting episodes, leg pains, sleeping with more than one pillow	□
GI	Abdominal pain, bloating, nausea, vomiting, diarrhea, constipation, jaundice, black stools, blood in stools, difficulty swallowing, hemorrhoids	□
Genitourinary	Painful urination, increased frequency, urgency, leaking urine, blood in urine, kidney stones, urinating at night, incomplete emptying of bladder	□
Breasts	Discharge, mass, pain, tenderness	□
Musculoskeletal	Arthritis, joint stiffness, swelling, back pain, swelling, weakness	□
Nervous System	Headaches, seizure, dizziness, tremors, memory loss, paralysis, numbness, tingling	□
Psychiatric	Anxiety, depression, personality change, suicidal thoughts	□
Female Reproductive	Pelvic pain, irregular periods, absent periods, bleeding in between periods, bleeding after intercourse, painful intercourse, abnormal vaginal discharge/bleeding, hot flashes	□
Lymph nodes	Enlargement, tenderness	□
Hematologic	Bruising, bleeding, recurrent infections	□

Patient Name _____

Date of Birth _____

Gynecologic History (Female Only)

- At what age did you start menstruating? _____years old
- Last menstrual period: ____/____/____
- Are you pregnant? □ Yes □ No
- *Total* number of pregnancies_____ Miscarriages/terminations_____ Number living children_____
- Age at first pregnancy _____years old
- Do you wish to maintain future fertility? □ Yes □ No □ Not applicable
- Are you sexually active? □ Yes □ No
- Onset of menopause: _____year/age
- Last Pap smear: ____/____/____
- Any abnormal Pap smears? □ Yes □ No Description: _____
- Any history of pelvic infections (Gonorrhea, Chlamydia, herpes)? Description: _____
- Did you ever breast feed? □ Yes □ No If yes, for how long?_____
- Have you ever taken oral contraceptive pills? □ Yes □ No If yes, for how long?_____
- Have you ever taken hormone replacement therapy? □ Yes □ No If yes, for how long?_____
- Are you currently on a bisphosphonate (Aredia, Fosamax, Boniva, Reclast, Prolia, Actonel, Olpadronate, Nerixia)?