MONTGOMERY
CANCER CENTER
A BAPTIST HEALTH FACILITY

PATIENT HISTORY FORM

DEMOGRAPHICS

Today's Date: ___/___/___ Patient's Name: ____
First MI Last

Date of Birth: ___/___/___ Sex: ❑ Male ❑ Female Race: ❑ African American ❑ Caucasian ❑ Asian ❑ Latin ❑ American Indian/Aleut ❑ Pacific Islander ❑ Other

SS#: _____–____–______ Preferred Language: ____________________ Ethnicity: ______________________________

Referring Doctor: ___________________________________ Preferred Pharmacy: ______________________________

Reason for your visit: ____

Do you have a living will? ❑ Yes ❑ No Do you have a durable power of attorney? ❑ Yes ❑ No

PMH

Illnesses / Diseases – check all that apply to you

❑ Heart Attack ❑ Hypertension ❑ Heart Disease ❑ Unusual Bleeding ❑ Blood Disorders ❑ Blood Clots

❑ Stroke ❑ Kidney Stones ❑ Diabetes ❑ Emphysema ❑ Other (describe below)

❑ Previous Cancer (describe below) Type of Cancer: ______________________________ Diagnosis date: ________________

____

____

SURGICAL / TREATMENT HISTORY

Previous Surgery	Date of Surgery	Surgeon's Name

Please list any injuries:

Have you had previous treatment for cancer? ❑ Yes ❑ No

Prior Radiation? ❑ No ❑ Yes Area: ____________________________________ # of Treatments: ________ Year: __________

Prior Chemotherapy? ❑ No ❑ Yes Type: ____ Year: __________

FAMILY HISTORY

Check all that apply and indicate with age diagnosed:	Heart Attack	Heart Disease	Stroke	Blood Clots	Blood Disorders	Unusual Bleeding	Diabetes	Cancer (indicate below)	Other (indicate below)
FATHER ❑ living ❑ deceased **AGE:**									
MOTHER ❑ living ❑ deceased **AGE:**									
BROTHER ❑ living ❑ deceased **AGE:**									
SISTER ❑ living ❑ deceased **AGE:**									
CHILDREN ❑ living ❑ deceased **AGE:**									
GRANDPARENTS **AGE:** ❑ living ❑ deceased ❑ maternal ❑ paternal									
OTHER FAMILY MEMBER ❑ living ❑ deceased **AGE:**									

SOCIAL HISTORY

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Primary Caregiver: ______________________________

Children: ❑ No ❑ Yes - # of children: _____ Education: Highest grade/degree completed: __________________________

Occupation: ____ Retired? ❑ No ❑ Yes

If retired, list previous occupation

Any exposure to hazardous materials? ❑ No ❑ Yes Type: ____

PLEASE COMPLETE OTHER SIDE

SOCIAL HISTORY (continued)

Alcohol use at present? ❑ No ❑ Yes If yes, how much? ___________________________ How often: _____________________

In the past? ❑ No ❑ Yes If yes, when did you quit? ____(date)

Tobacco use at present? ❑ No ❑ Yes Type: ❑ Cigarettes ❑ Cigars ❑ Oral Tobacco Daily amount: _______ # of years _______

❑ Every day tobacco use ❑ Some day tobacco use

In the past? ❑ No ❑ Yes If yes, when did you quit? ____(date)

Any illicit / recreational / street drug use / abuse? ❑ No ❑ Yes

If yes, please describe: ____

ALLERGIES

Any known drug allergies? ❑ No ❑ Yes (please list below)	(type of adverse reaction)

MEDICATIONS

❑ List your medications ❑ Provided list	Dosage	How often

NUTRITION: ❑ Regular Diet ❑ Vegetarian ❑ Nutritional Supplement ❑ Liquid Diet

SUPPORT SYSTEM

❑ Lives with spouse ❑ Lives alone ❑ Lives in assisted living	❑ Has transportation ❑ Needs transportation	❑ Needs referral for assistance

REVIEW OF SYSTEMS

Check all that apply:

❑ Weight Loss
❑ Fever
❑ Night Sweats
❑ Generalized weakness
❑ Loss of Appetite
❑ Double Vision
❑ Blurred Vision
❑ Ear Pain
❑ Throat Pain
❑ Hoarseness
❑ Trouble swallowing
❑ Pain in bones
❑ Pain in joints
❑ Depression
❑ Anxiety

❑ Shortness of Breath
❑ Coughing up blood
❑ Wheezing
❑ Cough: ❑ Wet ❑ Dry
❑ Chest pain
❑ Leg swelling
❑ Heart too fast / slow
❑ Nausea
❑ Vomiting
❑ Diarrhea
❑ Constipation
❑ Passing blood

❑ Headaches
❑ Fainting
❑ Dizziness
❑ Localized weakness / numbness
❑ Pain (where/describe)
____
Last Chest X-Ray (date) ________________________
❑ Other bleeding (where/describe)
____
____

Last Rectal Exam (date) ____
Last Colonoscopy/Flex Sig (date) ____
❑ Skin rashes/change in a mole (where/describe): ________________________________
____

FEMALES ONLY

Menstrual Cycle: ❑ Regular ❑ Irregular ❑ Heavy ❑ Light ❑ Passing clots
❑ Spotting between cycles ❑ Cramps

Date last menstrual cycle: ___/___/___ Menopause? ❑ No ❑ Yes If yes, date: ___/___/___

Date last pap smear: ___/___/___ Date last breast exam: ___/___/___ Bra size: ________ (Breast cancer patients only)

Date last mammogram: ___/___/___ Location: ____

____ __________________________ ________❑ a.m. ❑ p.m.

Patient/Responsible Party Signature Date Time

Was information on Advance Directives given to patient? ❑ Yes ❑ No (to be completed by MCC Staff)