MONTGOMERY CANCER CENTER
A BAPTIST MEDICAL CENTER SOUTH FACILITY

PATIENT HISTORY FORM

DEMOGRAPHICS

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

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

SS#: _____–____–_____ Preferred Language: _____

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

REVIEW OF SYSTEMS

Check all that apply:

❑ Weight Loss	❑ Shortness of Breath	❑ Headaches
❑ Fever	❑ Coughing up blood	❑ Fainting
❑ Night Sweats	❑ Wheezing	❑ Dizziness
❑ Generalized weakness	❑ Cough: ❑ Wet ❑ Dry	❑ Localized weakness / numbness
❑ Loss of Appetite	❑ Chest pain	❑ Pain (where/describe)
❑ Double Vision	❑ Leg swelling	_____
❑ Blurred Vision	❑ Heart too fast / slow	Last Chest X-Ray (date) _____
❑ Ear Pain	❑ Nausea	❑ Other bleeding (where/describe)
❑ Throat Pain	❑ Vomiting	_____
❑ Hoarseness	❑ Diarrhea	_____
❑ Trouble swallowing	❑ Constipation	
❑ Pain in bones	❑ Passing blood	
❑ Pain in joints	Last Rectal Exam (date) _____	
❑ Depression	Last Colonoscopy/Flex Sig (date) _____	
❑ Anxiety	❑ 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)