

DEMOGRAPHICS

PLEASE PRINT CLEARLY

PATIENT INFORMATION

NAME _____	BIRTHDATE _____
SOCIAL SEC # _____	AGE _____
ADDRESS _____	SEX _____
CITY _____	MARITAL STATUS _____
STATE/ZIP _____	SPOUSE'S NAME _____
PHONE # _____	OCCUPATION _____
FAX # _____	_____
CELL # _____	_____

PRIMARY INSURANCE

SECONDARY INSURANCE

CARRIER _____	CARRIER _____
MEMBER # _____	MEMBER # _____
GROUP # _____	GROUP # _____
ADDRESS _____	ADDRESS _____
CITY/STATE/ZIP _____	CITY/STATE/ZIP _____
PHONE # _____	PHONE # _____

INSURANCE GUARANTOR

EMPLOYER INFORMATION

HOLDER NAME _____	COMP. NAME _____
HOLDER SSN _____	ADDRESS _____
HOLDER D.O.B. _____	CITY _____
_____	STATE/ZIP _____
_____	PHONE # _____
_____	FAX # _____

PHYSICIAN INFORMATION

REFERRING M.D. _____	FAMILY M.D. _____
PHONE # _____	PHONE # _____
FAX # _____	FAX # _____
_____	ADDRESS _____
ONCOLOGIST _____	CITY _____
PHONE # _____	STATE/ZIP _____
FAX # _____	_____

EMERGENCY CONTACTS

NAME _____	NAME _____
RELATIONSHIP _____	RELATIONSHIP _____
ADDRESS _____	ADDRESS _____
CITY _____	CITY _____
STATE/ZIP _____	STATE/ZIP _____
HOME # _____	HOME # _____
CELL # _____	CELL # _____
WORK # _____	WORK # _____
_____	_____

HEALTH QUESTIONNAIRE

PLEASE PRINT CLEARLY

Patient Name: _____ Date: _____

MEDICAL PROBLEMS

Problem (Onset Date) _____

Have you been diagnosed with lupus, rheumatoid arthritis, collagen vascular disease, or ulcerative colitis? _____

If so, do you take steroids such as prednisone? _____

SURGICAL PROCEDURES

Procedure and Date: _____

FAMILY HISTORY

(Check appropriate answer)

Age at Death, Cause of Death, and any Medical Problems (including Cancer)

Alive

Father No Yes _____

Mother No Yes _____

Son No Yes _____

Daughter No Yes _____

Other Relative No Yes _____

SOCIAL HISTORY

(Check appropriate answer)

Smoking: No Yes Frequency: _____ Number of Years: _____

Years since quitting: _____

Alcohol Consumption: No Yes Frequency: _____ Number of Years: _____

Years since quitting: _____

Prior Radiation Therapy (site treated, name of center, date) _____

Occupation (if retired, previous occupation) _____

Marital Status and Number of Children _____

City Where You Currently Live _____

ALLERGIES

Drug and Response (Example: Penicillin results in hives) _____

REVIEW OF SYSTEMS

Do you have the following?

General

Relatively good health most of your life No Yes
 Weight change over past 6 mos. +/- lbs. No Yes

Skin

Serious skin problems No Yes
 Jaundice No Yes
 Hives, rashes, or eczema No Yes
 Infections or boils No Yes
 Unusual pigmentation No Yes

Head

Serious headaches or injuries No Yes

Eyes

Glasses No Yes
 Condition: _____
 Serious eye diseases or injuries No Yes
 Double vision No Yes
 Glaucoma No Yes

Ears, Nose and Throat

Runny Nose No Yes
 Nosebleeds No Yes
 Impaired hearing No Yes
 Dizziness or episodes of unconsciousness No Yes
 Throat Problems No Yes

Respiratory

Spitting up blood No Yes
 Chronic cough No Yes
 Asthma or wheezing No Yes
 Shortness of breath No Yes
 Pleurisy or pneumonia No Yes

Neck

Thyroid illnesses No Yes
 Glandular enlargement No Yes

Cardiovascular

Chest pain or angina pectoris No Yes
 Shortness of breath while resting No Yes
 Heart trouble or heart attacks No Yes
 Date(s): _____
 High blood pressure No Yes
 Swelling of hands, feet or ankles No Yes
 Other known heart disease No Yes
 Specify: _____

Gastrointestinal

Peptic ulcer (stomach or duodenal) No Yes
 Vomiting blood No Yes
 Liver trouble No Yes
 Hepatitis; if yes A, B, or C (circle one) No Yes
 Painful bowel movements No Yes

Gastrointestinal (cont'd)

Bleeding with bowel movements No Yes
 Heartburn or indigestion No Yes
 Cramping No Yes
 Trouble swallowing No Yes
 Black stools No Yes
 Hemorrhoids or piles No Yes
 Recent change in bowel habits No Yes
 Frequent diarrhea No Yes
 Regular bowel movements No Yes

Gynecological (if applicable)

Gynecological problems No Yes
 Currently pregnant No Yes
 Date of last pregnancy test _____
 Age when periods started _____
 Age at first delivery _____
 Number of pregnancies _____
 Number of miscarriages _____
 Age when periods ended _____
 Menopause reason, e.g. surgery _____
 # yrs of contraceptive hormone use _____
 # yrs of postmenopausal hormone use _____
 Date and results of last pap smear _____

 Date and results of last mammogram _____

Musculoskeletal

Arthritis; (Circle: osteo or rheumatoid) No Yes
 Muscle-joint weakness or diseases No Yes

Neurological

Fainting spells No Yes
 Convulsions No Yes
 Paralysis No Yes
 Strokes No Yes
 Head injuries No Yes
 Seizures No Yes

Hematological

Bruise easily or heal slowly No Yes
 Blood disease No Yes
 Anemia No Yes
 Phlebitis No Yes
 Unusual bruising No Yes
 Bleeding with injuries or dental work No Yes

Psychiatric

Psychiatric history No Yes

Endocrine

Hormonal problems No Yes
 Endocrine problems No Yes

