

# Overlake Cancer Center - Health History

Page 1

*Information provided will be held STRICTLY CONFIDENTIAL. Please complete both sides in full.*

Name \_\_\_\_\_ Date \_\_\_\_\_

Referring MD \_\_\_\_\_ Primary MD \_\_\_\_\_

Occupation \_\_\_\_\_

Single  Married  Divorced  Widowed

Why are you being seen today? \_\_\_\_\_

**Medical/Surgical History:** *List illnesses, surgeries, and injuries with dates*

1. \_\_\_\_\_ Year(s) \_\_\_\_\_
2. \_\_\_\_\_ Year(s) \_\_\_\_\_
3. \_\_\_\_\_ Year(s) \_\_\_\_\_
4. \_\_\_\_\_ Year(s) \_\_\_\_\_
5. \_\_\_\_\_ Year(s) \_\_\_\_\_
6. \_\_\_\_\_ Year(s) \_\_\_\_\_

**Medication Allergies:** Yes  No

If yes, what medications? \_\_\_\_\_

**Medications:** Please list all prescription and over the counter medications you are currently taking

Medication	Dose	Frequency	Medication	Dose	Frequency

**Family History:** *list significant medical history &/or cause of death (e.g. heart disease, cancer, diabetes, gastrointestinal problems, etc)*

Relative	Age(s)	Significant Medical Problems	Cause of Death
<b>Mother</b>			
<b>Father</b>			
<b>Brother(s)</b>			
<b>Sister(s)</b>			
<b>Children</b>			
<b>Other</b>			

**Other History:**

Do you now, or did you ever smoke? Yes  No

If yes, how much and how long? \_\_\_\_\_

Do you now, or did you ever drink alcohol? Yes  No

If yes, how much and how long? \_\_\_\_\_

Have you ever used intravenous drugs? Yes  No

(over)

# Overlake Cancer Center - Health History

Page 2

## Woman only:

Are you currently pregnant? YES  NO

Age at menarche (first period)\_\_\_\_\_

Number of pregnancies\_\_\_\_\_

Have you gone through menopause? YES

Have you used oral contraceptives? YES

Have you used hormone replacement therapy? YES

Number of children\_\_\_\_\_

Age at first pregnancy\_\_\_\_\_

NO  If yes, at what age?\_\_\_\_\_

NO  If yes, for how many years?\_\_\_\_\_

NO  If yes, for how many years?\_\_\_\_\_

## System Review: Please check significant past or current symptoms or medical problems below

### Constitutional:

Recent weight change Yes  No

Poor appetite Yes  No

Fever Yes  No

Night sweats Yes  No

Fatigue Yes  No

Other:\_\_\_\_\_ Yes  No

### Gastrointestinal:

Difficulty swallowing Yes  No

Nausea/vomiting Yes  No

Diarrhea Yes  No

Constipation Yes  No

Bloating Yes  No

Abdominal Pain Yes  No

Recent change in bowel habit Yes  No

Blood in or black/tarry stool Yes  No

Other:\_\_\_\_\_ Yes  No

### Eyes/Ears/Nose/Throat:

Blurred vision Yes  No

Glaucoma Yes  No

Hearing loss Yes  No

Ringing in ears Yes  No

Mouth Sores Yes  No

Other:\_\_\_\_\_ Yes  No

### Musculoskeletal:

Joint pain or swelling Yes  No

Back or muscle pain Yes  No

Other:\_\_\_\_\_ Yes  No

### Cardiovascular:

Chest pain Yes  No

Irregular heart beat Yes  No

Shortness of breath Yes  No

Swelling of ankles Yes  No

Other:\_\_\_\_\_ Yes  No

### Skin/Breast:

Rash Yes  No

Itching Yes  No

Breast pain/discharge/skin change Yes  No

Other:\_\_\_\_\_ Yes  No

### Respiratory:

Shortness of breath Yes  No

Chronic cough Yes  No

Spitting up blood Yes  No

Wheezing Yes  No

Other:\_\_\_\_\_ Yes  No

### Neurological/Psychological:

Headaches Yes  No

Weakness or numbness Yes  No

Depression Yes  No

Memory loss/confusion Yes  No

Other:\_\_\_\_\_ Yes  No

### Genitourinary:

Burning with urination Yes  No

Blood in urine Yes  No

Difficulty starting urine Yes  No

Frequent nighttime urination Yes  No

Impotence Yes  No

Other:\_\_\_\_\_ Yes  No

### Endocrine:

Heat or cold intolerance Yes  No

Excessive thirst or urination Yes  No

### Hematological:

Easy bruising/bleeding Yes  No

Anemia Yes  No

Past transfusion Yes  No

(over)