

NEBRASKA CANCER SPECIALISTS
PATIENT HISTORY FORM / REVIEW OF SYSTEMS

01/2010

PATIENT NAME: _____ **DATE OF BIRTH:** _____

TODAY'S DATE: _____

HORMONAL THERAPY/BIRTHCONTROL USE? _____

PRIMARY PHYSICIAN: _____

If yes, medication and how long? _____

REASON FOR TODAY'S VISIT: _____

ALCOHOL : QUANTITY PER WEEK: _____

TOBACCO USE: (circle) current never past

TRAVEL TIME TO THIS CLINIC: _____

Total years smoking _____ Year quit _____

PREVIOUS CANCER DIAGNOSES

Amount / packs per day _____

TYPES OF CANCER: _____

ILLICIT DRUG USE? (circle) yes no

TREATMENT RECEIVED AND WHERE: _____

WORK HISTORY

OCCUPATION(S): _____

PERSONAL MEDICAL HISTORY

ANY MILITARY SERVICE: _____

ILLNESSES/MEDICAL PROBLEMS _____

IF YES, JOB YOU PERFORMED: _____

PAST SURGERIES _____

ANY EXPOSURE TO CHEMICALS, RADIATION, TOXINS,
FUMES, OR ASBESTOS? _____

ALLERGIES _____

FAMILY HISTORY

(Such as history of cancer, heart disease, and/or diabetes
in your relatives?)

RELATIVE AGE ILLNESSES

FATHER: _____

MOTHER: _____

SISTER: _____

SOCIAL HISTORY

MARITAL STATUS: (circle)

single married life partner divorced widowed

Live with _____

Age of 1st menstrual period _____ Age at menopause _____

BROTHER: _____

OF PREGNANCIES: _____ # OF CHILDREN: _____

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CONSTITUTIONAL YES NO
 Weight loss in past year ___ ___
 Fever in last month ___ ___
 Night sweats ___ ___
 Fatigue ___ ___
 Appetite change ___ ___

SKIN YES NO
 Rash ___ ___
 Itchiness ___ ___

EYES, EARS, NOSE, THROAT YES NO
 Blurred or double vision ___ ___
 Nose bleeds ___ ___
 Hearing loss ___ ___
 Mouth sores ___ ___
 Sore throats ___ ___
 Hoarseness ___ ___
 Trouble swallowing ___ ___
 Sinus problems ___ ___

RESPIRATORY YES NO
 Shortness of breath ___ ___
 Cough ___ ___
 Coughing up blood ___ ___
 Bronchitis ___ ___
 Pneumonia ___ ___
 Emphysema or COPD ___ ___
 Asthma ___ ___
 Blood clots to lung ___ ___

CARDIOVASCULAR YES NO
 Chest pain ___ ___
 Palpitations ___ ___
 Swelling in feet or legs ___ ___
 High blood pressure ___ ___
 Heart valve disease ___ ___
 Heart murmurs ___ ___
 Coronary artery disease ___ ___
 High cholesterol ___ ___
 Previous heart attack ___ ___
 Congestive heart failure ___ ___
 Irregular heart beat ___ ___
 Blood clots to leg/ arm ___ ___

GENITOURINARY YES NO
 Pain with urination ___ ___
 Blood seen in urine ___ ___
 Bladder infections ___ ___
 Kidney infections/stones ___ ___
 Kidney disease ___ ___
 Prostate Enlargement ___ ___

GYNECOLOGICAL YES NO
 Menstrual periods regular ___ ___
 History of ovarian cysts ___ ___

GYNECOLOGICAL YES NO
 Any breast biopsies in past ___ ___
 Fibrocystic breasts ___ ___
 Are you menopausal ___ ___
 Age when menopause began: _____
 Age menstrual periods began: _____
 Date of last menstrual period: _____
 Date of last pap/pelvic exam: _____
 Date of last mammogram: _____

GASTROINTESTINAL YES NO
 Nausea/ vomiting ___ ___
 Abdominal pain ___ ___
 Liver disease/hepatitis ___ ___
 Peptic ulcers ___ ___
 Diarrhea ___ ___
 Rectal bleeding ___ ___
 Constipation ___ ___
 Colonoscopy ever ___ ___

HEMATOLOGIC YES NO
 Anemia ___ ___
 Low platelet counts ___ ___
 Enlarged lymph glands ___ ___
 Abnormal bleeding ___ ___
 Familial Thalassemia ___ ___
 Excessive bruising ___ ___

ENDOCRINE YES NO
 Diabetes ___ ___
 Thyroid disease ___ ___

MUSCULOSKELETAL YES NO
 Arthritis ___ ___
 Osteoporosis ___ ___
 Joint pain ___ ___
 New bone pain ___ ___
 Fractures ___ ___

NEUROLOGICAL YES NO
 Headaches ___ ___
 Dizziness ___ ___
 Fainting ___ ___
 Seizures ___ ___
 Difficulty walking ___ ___
 Numbness feet/ hands ___ ___
 Stroke ___ ___

PSYCHOSOCIAL YES NO
 Depression ___ ___
 Anxiety ___ ___
 Insomnia ___ ___
 Mental illness ___ ___
 Drug abuse ___ ___
 Alcohol abuse ___ ___

MD NOTES: