New Patient & Family History

ILLINOIS CANCER SPECIALISTS

We are looking forward to your upcoming visit with . Please fill out this form prior to your appointment to enable us to prepare for your visit.

Your appointment is scheduled for: at am/pm

Last First M.I. Today's Date

Date of Birth Home Phone Work Phone Cell Phone

Practice Physician (if you have one) Referring Physician Ref MD Phone

Sex: ☐ Male ☐ Female Race: _____

Your Mother's Family Country/Countries of Origin: _____ Jewish: ☐Yes ☐No ☐Unsure

Your Father's Family Country/Countries of Origin: _____ Jewish: ☐Yes ☐No ☐Unsure

Please list any genetic counseling or testing you or your family members have had:

_____

_____

PERSONAL MEDICAL HISTORY: Please list the following.

Cancer Diagnoses (with dates)	**Other Medical Problems**	**Surgical History**

Have you:

Have you ever had a breast biopsy: ☐Yes ☐No If yes, when? _____

Results: _____

Reproductive History:

Number of Pregnancies	_____	Number of Children	_____	Age at first pregnancy	_____
Did you breast feed?	☐Y ☐N	If yes, how many mos.?	_____		
Age at first period:	_____	Age at menopause:	_____	Age of last period:	_____
Hysterectomy:	☐Y ☐N	Ovaries Intact?	☐Y ☐N	If no, please explain	_____
Hormone Use:	☐Y ☐N	Sex Drive:	☐Y ☐N	Birth Control Method:	_____

For Office Use Only
Pt. Name_____
DOB: _____

Preventive Health Maintenance: **Please provide dates for each answer or write "none"**

Female		Male	
Last Mammogram:		Last Colonoscopy:	
Last Pap Smear:		Number of Polyps:	
Last Colonoscopy:		Last Prostate Exam:	
Number of Polyps:		Last PSA Screening:	
Last Bone Density Scan:			

FAMILY HISTORY

Family Member	DOB	Age at Death	Cancer History	Age at Diagnosis	Benign Growths (i.e. colon polyps)
Mother					
Father					
Mother's mother					
Mother's father					
Father's mother					
Father's father					
Maternal Aunts					
Maternal Uncles					
Paternal Aunts					
Paternal Uncles					
Sisters					
Bothers					
Children					
Other family members with cancer (include relationship)					

For Office Use Only
Pt. Name_____
DOB: _____

Please fill out the below information if you are a new patient to Virginia Cancer Specialists.

REVIEW OF SYSTEMS

Constitutional

Weight Loss	☐Y ☐N
Poor Energy Level	☐Y ☐N
Fever	☐Y ☐N
Chills	☐Y ☐N
Night Sweat	☐Y ☐N

Eyes

Double Vision	☐Y ☐N
Vision Loss	☐Y ☐N
Flashing Lights	☐Y ☐N

ENT/Mouth

Ringing in Ears	☐Y ☐N
Oral Ulcers	☐Y ☐N
Nasal Drip	☐Y ☐N
Hearing Loss	☐Y ☐N
Bleeding Gums	☐Y ☐N
Mouth Pain	☐Y ☐N
Nose Bleeds	☐Y ☐N
Sore Throat	☐Y ☐N
Difficulty Swallowing	☐Y ☐N
Hoarseness	☐Y ☐N
Sinus Pain	☐Y ☐N

Cardiovascular

Chest Pain	☐Y ☐N
Leg Swelling	☐Y ☐N
Palpitations	☐Y ☐N
Calf Discomfort	☐Y ☐N
Fainting Spells	☐Y ☐N
Arm Swelling	☐Y ☐N

Respiratory

Cough	☐Y ☐N
Wheezing	☐Y ☐N
Shortness of Breath	☐Y ☐N
Coughing Blood	☐Y ☐N
Pain with Breathing	☐Y ☐N

Breast

Mass	☐Y ☐N
Pain	☐Y ☐N
Nipple Discharge	☐Y ☐N
Change in Size	☐Y ☐N
Change in Shape	☐Y ☐N

Gastrointestinal

Nausea	☐Y ☐N
Vomiting	☐Y ☐N
Jaundice	☐Y ☐N
Abdominal Pain	☐Y ☐N
Maroon/Black Stool	☐Y ☐N
Constipation	☐Y ☐N
Abdominal Cramping	☐Y ☐N
Diarrhea	☐Y ☐N
Stomach Pain	☐Y ☐N
Vomiting Blood	☐Y ☐N
Difficulty Swallowing	☐Y ☐N

Urinary

Painful Urination	☐Y ☐N
Blood in Urine	☐Y ☐N
Increased Frequency	☐Y ☐N
Loss of Control	☐Y ☐N
Impotence	☐Y ☐N

Gynecological

Vaginal Discharge	☐Y ☐N
Pelvic Pain	☐Y ☐N
Abnormal Bleeding	☐Y ☐N
Vaginal Dryness	☐Y ☐N

Musculoskeletal

Muscle Pain	☐Y ☐N
Spine Tenderness	☐Y ☐N
Swollen Joints	☐Y ☐N
Joint Redness	☐Y ☐N
Bone Pain	☐Y ☐N

Skin

Rash	☐Y ☐N
Nodules	☐Y ☐N
Itchiness	☐Y ☐N
Lesions	☐Y ☐N

Neurological

Confusion	☐Y ☐N
Seizures	☐Y ☐N
Fainting Spells	☐Y ☐N
Tremors	☐Y ☐N
Speech Change	☐Y ☐N
Headache	☐Y ☐N
Hiccups	☐Y ☐N
Abnormal Gait	☐Y ☐N
Weakness	☐Y ☐N
Sensory Change	☐Y ☐N

Psychiatric

Depression	☐Y ☐N
Anxiety	☐Y ☐N
Lack of Concentration	☐Y ☐N

Endocrine

Excessive Urine	☐Y ☐N
Excessive Thirst	☐Y ☐N
Hot Flashes	☐Y ☐N
Heat/Cold Tolerance	☐Y ☐N

Hematological

Nose Bleeds	☐Y ☐N
Bleeding Gums	☐Y ☐N
Purple Spots on Hands	☐Y ☐N
Bruising	☐Y ☐N

Lymphatic

Enlarged lymph nodes	☐Y ☐N
Swelling in arms	☐Y ☐N

REFERRING PHYSICIANS: **Please list all referring physicians and those you are currently seeing.**

Physician	Medication List
_____	_____
_____	_____
_____	_____
_____	_____

For Office Use Only
Pt. Name_____
DOB: _____