ILLINOIS CANCER SPECIALISTS

PATIENT HEALTH HISTORY

DATE: _____

DEMOGRAPHICS

Name: _____ **Date of Birth**: _____

Ethnicity (optional): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (optional):

☐ White ☐ Black or African American ☐ Asian Indian ☐ Japanese ☐ Native Hawaiian
☐ Chinese ☐ Guamanian or Chamorro ☐ Korean ☐ Filipino ☐ Vietnamese
☐ Samoan ☐ Other Asian (Please state): _____ ☐ Other Race: _____

Sex: ☐ Male ☐ Female

PREFERRED LANGUAGE

Is English your preferred Language? ☐ Yes
☐ No, What is your preferred language? _____

MAIN PROVIDER

Primary Care Physician: _____ Phone Number: _____
Referring Physician: _____ Phone Number: _____

Current problem or reason for consultation: _____

VACCINATIONS

Vaccination	Last Administration Date (MM/YYYY)
Pneumonia	
Flu	
Shingles	
Pneumococcal	
Tuberculosis (TB)	

Vaccination	Last Administration Date (MM/YYYY)
Hepatitis B	
DT	
DPT	
Tetanus	
Other	

PAST MEDICAL HISTORY: PLEASE CHECK ALL THE BOXES THAT APPLY

☐ Anemia/Blood disorders
☐ Arthritis
☐ Asthma
☐ Autoimmune disease
☐ Blood Clots
☐ Cancer
☐ Cataracts
☐ Colitis
☐ Diabetes
☐ Emphysema
☐ GERD
☐ Glaucoma
☐ Heart Disease
☐ Hepatitis/Liver disease
☐ Hypercholesterolemia
☐ Hypertension
☐ Irregular heartbeat
☐ Kidney disease
☐ Pancreatitis
☐ Sickle Cell disease
☐ Sinusitis
☐ Stroke
☐ Thyroid
☐ Tuberculosis
☐ Ulcers
☐ Other: _____

Any unusual childhood infections or illnesses? _____

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MEDICAL SURGICAL HISTORY

Operation	Date (MM/YYYY)	Reason	Surgeon/Facility

HOSPITALIZATION

Have you been hospitalized with in the last year? ☐ Yes ☐ No

If yes, please describe reason, facility and dates: _____

SCREENING TESTS

Have you had any screening tests?

Screening Test	Completed	Date	Results
Mammogram	☐ Yes ☐ No ☐ N/A		
Breast Exam	☐ Yes ☐ No ☐ N/A		
Pap Smear/Pelvic Exam	☐ Yes ☐ No ☐ N/A		
Stool for Occult Blood	☐ Yes ☐ No ☐ N/A		
Colonoscopy/Sigmoidoscopy	☐ Yes ☐ No ☐ N/A		
Prostate Exam	☐ Yes ☐ No ☐ N/A		
PSA	☐ Yes ☐ No ☐ N/A		
Chest X-Ray/CT (Smokers)	☐ Yes ☐ No ☐ N/A		
Bone Density	☐ Yes ☐ No ☐ N/A		
Dermatology Skin Screening	☐ Yes ☐ No ☐ N/A		
Eye Exam	☐ Yes ☐ No ☐ N/A		
Other: _____			

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PATIENT HEALTH HISTORY

NAME: _____

SOCIAL HISTORY

Number of Children: _____

Age/Sex of Children: _____

Spouse/Partner's Name: _____

ALCOHOL USE

Do you drink beer, wine, or liquor? ☐ Yes ☐ No

If yes, How many drinks per:

Day: _____ Week: _____ Month: _____ Year: _____

Did you quit? ☐ Yes ☐ No

When did you quit? _____

Have you ever sought help for drinking? ☐ Yes ☐ No

SMOKING USE

Do you currently smoke? ☐ Yes ☐ No

If yes, what do you smoke?

☐ Cigarettes How often per Day/Week: _____

☐ Cigars How often per Day/Week: _____

☐ Pipe How often per Day/Week: _____

☐ Electronic Cigarettes How often per Day/Week: _____

☐ Smokeless/Chewing Tobacco How often per Day/Week: _____

Did you ever smoke? ☐ Yes ☐ No

If yes, how long did you smoke for? _____

When did you quit? _____

Do you wear a nicotine patch? _____

DRUG USE (RECREATIONAL)

Do you use recreational drugs, including marijuana? ☐ Yes ☐ No

If yes, what do you use: _____

How often: _____

If marijuana, is it medical marijuana? ☐ Yes ☐ No

Have you previously used recreational drugs? ☐ Yes ☐ No

If yes, when did you quit: _____

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PREFERRED PHARMACY

Please indicate the pharmacy you are currently using for your prescriptions. If you are using a mail order pharmacy, specialty pharmacy or another pharmacy out of state, please include that information as well.

Pharmacy Name: _____ Type (circle one): Retail Mail Order Specialty
Address/Cross Roads: _____
City:_____ State: _____ Zip Code: _____
Phone number: _____ Fax number: _____

Pharmacy Name: _____ Type (circle one): Retail Mail Order Specialty
Address/Cross Roads: _____
City:_____ State: _____ Zip Code: _____
Phone number: _____ Fax number: _____

MEDICATION LIST

Please list all the medications you are currently taking. Be sure to include the dosage, how often and the doctor that has prescribed this medication for you. If you are taking any vitamins, over the counter medications or herbal supplements please also include these medications in the list below (you do not need to include the prescribing physician if not applicable).

PRESCRIPTION / OVER-THE-COUNTER			
Drug Name	**Dose/Strength of Medication**	**How often you take Medication**	**Prescribing Physician**

Please list any herbal supplements you are currently taking (probiotics, vitamins, etc.).

Herbal Supplements	Dose/Strength	How often you take Supplement

ALLERGIES

Do you have any allergies? ☐ Yes ☐ No

If yes, please list any medications, food or substances that you are allergic to. If applicable, please list the reaction (i.e. swelling, itching, shortness of breath, etc.)

Name of medication, food or substance:	Type of Reaction:

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PATIENT HEALTH HISTORY

NAME: _____

FAMILY MEDICAL HISTORY

Please mark (Y) for all those that apply to YOUR FAMILY. Please mention relationship(s) to you and the age of diagnosis for each cancer in your family.

The following close blood relatives should be considered: You, parents, brothers, sisters, sons, daughters, grandparents, grandchildren, aunts, uncles, nephews, nieces, half-siblings, first cousins, great grandparents & great grandchildren.

YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF DIAGNOSIS	PARENTS / SIBLINGS / CHILDREN	AGE of Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE of Diagnosis	RELATIVES on your FATHER'S SIDE	AGE of Diagnosis
☒ Y ☐ N	EXAMPLE: BREAST CANCER		---	---	Aunt Cousin	45 61	Grandmother	53
☐ Y ☐ N	BREAST CANCER (Female or Male)							
☐ Y ☐ N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
☐ Y ☐ N	UTERINE (ENDOMETRIAL) CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	10 or more LIFETIME COLORECTAL POLYPS (Specify #)							
☐ Y ☐ N	OTHER CANCER(S) (Specify cancer type)							

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?
(Please explain/include a copy of result if possible)

For other close blood relatives such as grandparents, aunts and uncles: Please check all boxes that apply

- ☐ Anemia/Blood Disorders
- ☐ Blood Clots
- ☐ Blood Disorders
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke

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REVIEW OF SYSTEMS

General	☐ Fever	☐ Weight Loss	☐ Fatigue
	☐ Chills	☐ Weight Gain	☐ Night Sweats
Head	☐ Headaches	☐ Ringing in ears	☐ Toothache
	☐ Blackouts	☐ Sinusitis	☐ Double Vision
	☐ Seizures	☐ Post Nasal Drip	☐ Blurred Vision
	☐ Dizziness	☐ Sore Throat	☐ Cataracts
	☐ Hearing Loss	☐ Hoarseness	☐ Glaucoma
	☐ Earache	☐ Sore Tongue	
	☐ Bleeding Gums	☐ Nosebleeds	
Neck	☐ Lumps	☐ Goiter	☐ Pain or Stiffness
	☐ Pain when swallowing	☐ Difficulty swallowing	
Chest	☐ Cough	☐ Shortness of Breath	☐ Heart Murmur
	☐ Sputum	☐ Chest Pain	☐ Rheumatic Fever
	☐ Coughing Up Blood	☐ Palpitations	☐ High Blood Pressure
	☐ Wheezing	☐ Swelling of feet	
	☐ Bronchitis	☐ Asthma	
Breast	☐ Lumps	☐ Pain	☐ Nipple Discharge
Abdomen	☐ Nausea	☐ Ulcer	☐ Hemorrhoids
	☐ Vomiting	☐ Gas	☐ Blood in stools
	☐ Indigestion	☐ Bloating	☐ Black stools
	☐ Abdominal pain	☐ Constipation	
	☐ Hiatal Hernia	☐ Diarrhea	
Urinary	☐ Blood in urine	☐ Difficulty starting to urinate	☐ Getting up at night to urinate
	☐ Burning with urination	☐ Bladder/Kidney Infections	☐ Sense of full bladder
	☐ Frequent urination		
Gynecology	☐ Spotting	☐ Cramping	☐ Discharge
	☐ Vaginal infections		
	Last Menstrual Period: _____	Duration: _____	Interval: _____
	Number of pregnancies: _____	Number of live births: _____	
Skin	☐ Rash	☐ Itching	☐ Change in hair or nails
Neuromuscular	☐ Joint Stiffness	☐ Swelling	☐ Night Cramps
	☐ Joint Pain	☐ Back Pain	☐ Varicose veins
Hematological	☐ Easy bruising or bleeding	☐ Anemia	☐ Past Infusion
			☐ Transfusion Reactions
Endocrine	☐ Thyroid Problems	☐ Hot or cold intolerance	☐ Excessive thirst or hunger
Psychiatric	☐ Anxiety	☐ Depression	☐ Memory Loss
	☐ Nervousness		

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OTHER PROVIDERS

Please list all providers involved in you care within the last 3 years:

Provider Type	Physician (first and last name)	Phone Number
Primary Care Physician		
Surgeon		
Cardiologist		
Endocrinologist		
Neurologist		
Urologist		
Pulmonologist		
Dentist		
Oral surgeon		
Optometrist		
Orthopedic		
Gynecologist		
Podiatrist		
Dermatologist		
Rheumatologist		
Other: _____		

Patient Signature: _____ **Date**: _____