ILLINOIS CANCER SPECIALISTS

PATIENT HEALTH HISTORY

NAME: _____

DEMOGRAPHICS

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

Sex: ☐ Male ☐ Female

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

Race (optional):

☐ White ☐ Black or African American ☐ Other: _____

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: _____

PAST MEDICAL HISTORY: PLEASE CHECK ALL THE BOXES THAT APPLY

- ☐ Anemia/Blood disorders
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Blood Clots
- ☐ Bronchitis
- ☐ Cataracts
- ☐ Colitis
- ☐ COPD
- ☐ Diabetes
- ☐ Emphysema
- ☐ GERD
- ☐ Glaucoma
- ☐ Goiter
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis/Liver disease
- ☐ Hiatal Hernia
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Irregular heartbeat
- ☐ Kidney disease
- ☐ Pancreatitis
- ☐ Rheumatic Fever
- ☐ Sickle Cell disease
- ☐ Sinusitis
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Other: _____

☐ Cancer (Please list type(s) and age at diagnosis): _____

Any unusual childhood infections or illnesses? _____

MEDICAL SURGICAL HISTORY

Operation	Date (MM/YYYY)	Surgeon/Facility

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Occupation:

Do you work Part-Time or Full-Time? ☐ Part-Time ☐ Full-Time ☐ Unemployed

What is your occupation: _____

Are you eligible for Family Medical Leave? ☐ Yes ☐ No

If yes, do you need help completing? ☐ Yes ☐ No

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 to quit? ☐ 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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FAMILY MEDICAL HISTORY

Please provide details of family medical history such as: Anemia/Blood Disorders, Blood Clots, and/or Cancer.

The following first-degree blood relatives should be considered: Parents, brothers, sisters, sons, and daughters.

The following second-degree blood relatives should be considered: Grandparents, grandchildren, aunts, uncles, nephews, nieces, half-siblings, first cousins, great grandparents, and great grandchildren.

NOTE: If you have a family history of cancer, please complete the Family Cancer History Form.

Relative	Current Age or Age at Death	Medical History and Age at Diagnosis

VACCINATIONS

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

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

HOSPITALIZATION

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

If yes, please describe reason, facility and dates:

Date (MM/YYYY)	Reason	Hospital / Facility

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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/DEXA	☐ Yes ☐ No ☐ N/A		
Dermatology Skin Screening	☐ Yes ☐ No ☐ N/A		
Eye Exam	☐ Yes ☐ No ☐ N/A		
Other: _____			

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: _____

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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:	Severity / Type of Reaction:

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NAME: _____

REVIEW OF SYSTEMS

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

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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		
Ophthalmologist		
Orthopedic		
Gynecologist		
Podiatrist		
Dermatologist		
Rheumatologist		
Other: _____		

Patient Signature: _____ **Date**: _____

ILLINOIS CANCER SPECIALISTS

FAMILY CANCER HISTORY

DATE: _____

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

YOURSELF

Type(s) of Cancer	Age at Diagnosis

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

PARENTS

	Current Age or Age at Death	Type(s) of Cancer	Age at Diagnosis	Other Health Problems
Mother				
Father				

SIBLINGS AND/OR CHILDREN (Include half-siblings and denote maternal-half or paternal-half)

Relation	Gender	Current Age or Age at Death	Type(s) of Cancer	Age at Diagnosis	Other Health Problems
☐ Sibling ☐ Child	☐ M ☐ F				
☐ Sibling ☐ Child	☐ M ☐ F				
☐ Sibling ☐ Child	☐ M ☐ F				
☐ Sibling ☐ Child	☐ M ☐ F				

OTHER BLOOD RELATIVES (Grandparents, aunts, uncles, nieces, and nephews)

Relation	Maternal or Paternal	Current Age or Age at Death	Type(s) of Cancer	Age at Diagnosis	Other Health Problems
	☐ Maternal ☐ Paternal				
	☐ Maternal ☐ Paternal				
	☐ Maternal ☐ Paternal				

☐ 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)

Patient Signature: _____ **Date**: _____