**Medical History:** (Please check all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Seasonal Allergies |  | Gallbladder Disease |  | IBS / Crohn’s Disease |  |
| Anxiety |  | GERD (Acid Reflux) |  | Neuropathy |  |
| Arthritis |  | Heart Disease |  | Osteopenia/Osteoporosis |  |
| Asthma |  | Heart Attack |  | Rheumatoid Arthritis |  |
| Bladder Incontinence |  | Hemorrhoids |  | Seizure Disorder |  |
| COPD/Emphysema |  | High Blood Pressure |  | Skin Conditions\_\_\_\_\_\_\_\_ |  |
| Dementia |  | High Cholesterol |  | Stroke |  |
| Depression |  | HIV/AIDS |  | Thyroid Disorder |  |
| Diabetes |  | Hepatitis / TB |  | Ulcerative Colitis |  |

Please list any additional medical conditions you have that are not mentioned above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a pacemaker, internal defibrillator, or any other implanted electronic device? ❏ Yes ❏ No

Have you ever had a joint replacement surgery? ❏ Yes ❏ No

If yes, which joint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received an organ transplant? ❏ Yes ❏ No

If yes, which organ(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any surgeries, procedures, or hospitalizations:**

|  |  |  |
| --- | --- | --- |
| **Type of Surgery, Procedure, Hospitalization** | **Where was it performed?** | **When?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Cancer Screenings and Prior Cancer Treatments**

**(FEMALE PATIENTS ONLY)**

Date of last Mammogram? \_\_\_\_\_\_\_\_\_\_ Do you experience Urinary Incontinence? ❏ Yes ❏ No

Location? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had a bone density scan? (DEXA) ❏ Yes ❏ No

Date of last Pap Smear? \_\_\_\_\_\_\_\_\_\_\_\_ If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Pregnancies? \_\_\_\_\_\_\_

Number of Miscarriages? \_\_\_\_\_\_

Age of first menstrual period? \_\_\_\_\_\_\_ Number of Deliveries? \_\_\_\_\_\_\_\_

Age of last menstrual period? \_\_\_\_\_\_\_ Age at first pregnancy? \_\_\_\_\_\_\_

Have you ever taken any hormones, such as birth control, estrogen, androgens? ❏ Yes ❏ No

Is there a possibility you could be pregnant? ❏ Yes ❏ No

Have you had one of the following colorectal cancer screenings?

❏ Colonoscopy

❏ Fecal Occult Blood Test (FOBT)

❏ FIT Test

❏ Flexible Sigmoidoscopy

If yes, date(s) \_\_\_\_\_\_\_\_\_\_\_\_ and location(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with cancer before? ❏ Yes ❏ No

If yes, please answer the questions below:

What type of cancer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who Diagnosed you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received any radiation or cobalt treatments? (Includes treatments for birthmarks and dermatology reasons) ❏ Yes ❏ No Location? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received Chemotherapy? ❏ Yes ❏ No

If yes, please list what drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received any type of hormone therapy for cancer? ❏ Yes ❏ No

If yes, please list the medication and date taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Relationship:** | **Current Age** | **List Medical Conditions:** | **If Deceased, age and cause of death** |
| Father |  |  |  |
| Mother |  |  |  |
| Brother(s) |  |  |  |
| Sister(s) |  |  |  |
| Children |  |  |  |
| Other: |  |  |  |

**Social History**

Do you use any type of tobacco products? ❏ Never ❏ Yes ❏ Previously (year quit \_\_\_\_\_\_)

If yes, what type of tobacco products do you use? ❏ Cigarettes ❏ Pipe ❏ Cigar ❏ Chew/Dip

Frequency of use: \_\_\_\_\_ packs per day

Do you drink alcohol beverages? ❏ Never ❏ Occasionally ❏ Regularly

If regularly, how many drinks per day \_\_\_\_? per week \_\_\_\_\_?

How many times in the past year have you had four or more drinks in one day? \_\_\_\_\_\_

Do you use marijuana or recreational drugs? ❏ Yes ❏ No

Have you ever worked in an occupation that involved exposure to cancer causing chemicals, fumes or other carcinogens? ❏ Yes ❏ No

If yes, what exposure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication and Immunization List**

Have you received an influenza (flu) vaccine this season? ❏ Yes ❏ No If yes, date \_\_\_\_\_\_\_\_\_\_

Have you received a pneumococcal (pneumonia) vaccine? ❏ Yes ❏ No

Have you received a COVID vaccine? ❏ Yes ❏ No

List any allergies to any medications or drugs (including contrast, iodine, etc.. )

|  |  |
| --- | --- |
| Medication | Type of reaction? |
|  |  |
|  |  |
|  |  |

List any Medications you are currently taking, including OTC, vitamins and supplements:

|  |  |  |
| --- | --- | --- |
| Name of Medication | Strength/Dose | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Screening for Depression (PHQ-2)**

Are you currently under any treatment for mental illness or depression? ❏ Yes ❏ No

Name of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the past 2 weeks, how often have you been bothered by any of the following | Not at all | Several days | More than ½ of the days | Nearly every day |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

Patient declined to answer screening questions \_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_