EDWARDS CANCER CENTER | Gynecologic Oncology
A Division of Edwards Cancer Center

Place Label Here

PATIENT MEDICAL HISTORY FORM

Dear Patient,

Please return completed packet with signature pages to the front desk.

Patient Name: _____

DOB: ____/____/____ **Age**: _____ ❑ **Male** ❑ **Female** **SS#**: _____

Primary Address: _____

City: _____ State:_____ Zip: _____

Home Phone: ❑ Preferred (_____) _____

Cell Phone: ❑ Preferred (_____) _____

Secondary Address: _____

City: _____ State: _____ Zip: _____

May we leave a message on your answering machine/voicemail? ❑ Yes ❑ No

May we send an SMS text message to your cell phone? ❑ Yes ❑ No

Email Address: _____ May we email you? ❑ Yes ❑ No

Preferred Language: _____

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino

Race: ❑ Native American or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other

Pharmacy Name: _____

Pharmacy Phone # and Cross Streets: _____

(Internal Use Only)

MRN#: _____

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Patient Name: _____ **DOB:** _____

Primary Care Physician: _____Phone: _____

Referring Physician (if different): _____Phone: _____

Please list names of other physicians you see: (include phone #):

_____Phone: _____

_____Phone: _____

_____Phone: _____

_____Phone: _____

Emergency Contact Name:

_____

Relationship: _____Phone: (_____) _____

Employment Status:

❑ Employed/Self Employed ❑ Unemployed ❑ Retired ❑ Disabled

Occupation (or Former Occupation):_____

Name of Employer: _____ Work Phone: (_____) _____

Advanced Directives:

Living Will ❑ Yes ❑ No ❑ Unknown **Durable Power of Attorney** ❑ Yes ❑ No ❑ Unknown

DNR ❑ Yes ❑ No ❑ Unknown

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Patient Name: _____ **DOB:** _____

Menstrual History (complete even if post-menopausal or no longer having periods)

1. Age at first period: _____ years.

2. If your menstrual periods are regular; periods start every _____ days

3. If your menstrual periods are irregular; periods start every _____ to _____ days (e.g.,12 to 60)

4. Duration of bleeding: _____ days 5. Does bleeding or spotting occur between periods? ❑ Yes ❑ No

6. Does bleeding or spotting occur after intercourse? ❑ Yes ❑ No

7. First day of last menstrual period _____
month day year

8. Is pain associated with periods? ❑ Yes ❑ No ❑ Occasionally

9. If yes to question 8, is it: ❑ Before menses? ❑ During menses? ❑ Both?

Pregnancy History (all pregnancies) **Have never been pregnant** ❑

10. Obstetrical history including abortions & ectopic (tubal) pregnancies

						Child		
Year	Place of delivery or abortion	Duration of pregnancy	Hours of labor	Type of delivery	Complications mother and/or infant	Sex	Birth weight	Present health

Birth Control History

11. What birth control method(s) do you currently use? _____

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Patient Name: _____ **DOB:** _____

Sexual History

12. Do you have a sexual partner? ❑ Yes ❑ No (Male ❑ Female ❑)

13. Are there concerns about your sexual activity which you may want to discuss with your doctor? ❑ Yes ❑ No

Pap Smear/Mammogram History

14. Date of last pap smear: _____

15. Have you ever had abnormal pap smears? ❑ Yes ❑ No

16. Have you had treatment for abnormal smears? ❑ Yes ❑ No

If yes, what type(s) of treatment have you had? ❑ Cryotherapy ❑ Laser ❑ Cone biopsy ❑ Loop excision (LEEP)

Year of treatment _____

17. Date of last mammogram: _____
month year

18. Have you had an abnormal mammogram? ❑ Yes ❑ No

Other Past Gynecological History

19. Check any that apply:

None	❑	Venereal warts	❑	Herpes – genital	❑
Syphilis	❑	Pelvic inflammatory disease	❑	Endometriosis	❑
Chlamydia	❑	Gonorrhea	❑	Vaginal infections	❑
Other (specify)	❑				

_____

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Patient Name: _____ **DOB:** _____

Reason for this visit: _____

Medical History: Check the items that apply to you (current or past)

None	❑	Enlarged Prostate	❑	Leukemia	❑
Asthma	❑	Peripheral Vascular Disease (PVD)	❑	Anxiety	❑
Chronic Lung (COPD)	❑	Diabetes	❑	Problems with Anesthesia	❑
Pneumonia/Bronchitis	❑	Lupus-Autoimmune	❑	Thyroid Disease	❑
TB (Tuberculosis)	❑	Reynaud's Syndrome	❑	High Blood Pressure	❑
Sleep Apnea	❑	Rheumatoid Arthritis	❑	High Cholesterol	❑
Colon Polyps	❑	Osteoarthritis	❑	Atrial Fibrillation (Afib)	❑
Crohn's Disease	❑	Chronic Back Pain	❑	Congestive Heart Failure	❑
Diverticulitis	❑	Osteoporosis	❑	Heart Attack-MI	❑
Irritable Bowel Syndrome (IBS)	❑	Fracture	❑	Heart Disease	❑
Ulcerative Colitis	❑	Stroke	❑	Rheumatic Fever	❑
Stomach Ulcers	❑	Neuropathy	❑	Heartburn/Reflux	❑
GERD/Heartburn	❑	Parkinson's Disease	❑	Heart Murmur	❑
Hiatal Hernia	❑	Paralysis	❑	Irregular Heart Beat	❑
Gallstones	❑	Seizures	❑	Frequent Infections	❑
Cirrhosis of Liver	❑	Migraines	❑	Blood Disorder	❑
Hepatitis A/ B/ C	❑	Shingles	❑	Blood Clots	❑
Pancreatitis	❑	Glaucoma/Cataracts	❑	Anemia	❑
Kidney Stone	❑	Hearing Loss	❑	Bleeding Disorder	❑
Kidney Disease/Failure	❑	Cancer	❑	Drug Use	❑
Freq. Urinary Tract Infections (UTI)	❑	Lymphoma	❑	Depression	❑

Other Medical History: _____

Cancer History:

Type: _____ Date diagnosed _____

Treatment: (type, date and location of treatment) _____

_____

Treating Physician: _____

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Patient Name: _____ **DOB:** _____

Past Obstetrical/Gynelogical Surgeries: (Please circle and date any of the surgeries and/or procedures that you have undergone)

D&C	Date: _____	Ovarian surgery	Date: _____
Hysteroscopy	Date: _____	L cyst(s) removed ovarian	Date: _____
Infertility surgery	Date: _____	R cyst(s) removed ovarian	Date: _____
Tuboplasty	Date: _____	L ovary removed	Date: _____
Tubal ligation	Date: _____	R ovary removed	Date: _____
Laparoscopy	Date: _____	Vaginal or bladder repair	Date: _____
Hysterectomy (vaginal)	Date: _____	for prolapsed or incontinence	
Hysterectomy (abdominal)	Date: _____	Cesarean section	Date: _____
Myomectomy	Date: _____	Other (specify)	Date: _____
		_____	

Past Surgical History: (Please circle and date any of the surgeries and/or procedures that you have undergone)

Coronary Bypass	Date: _____	Knee Replacement	Date: _____
Angioplasty	Date: _____	Rotator Cuff Repair	Date: _____
Pacemaker	Date: _____	Cataract	Date: _____
Cardiac Valve Surgery	Date: _____	Gallbladder Surgery	Date: _____
Hemorrhoidectomy	Date: _____	Hysterectomy	Date: _____
Prostate Operation	Date: _____	Prostatectomy	Date: _____
Hernia Repair	Date: _____	Appendectomy	Date: _____
Tonsillectomy	Date: _____	Hip Replacement	Date: _____
Mastectomy	Date: _____	Lumpectomy	Date: _____

Other Operations: _____

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Patient Name: _____ **DOB:** _____

Social History:

Tobacco Use: (Present and/or Past):

❑ Never Smoked

❑ Quit smoking When? _____ How many years did you smoke? _____yr(s)
How many packs? _____/day

❑ Currently Smoke ❑ Cigarettes ❑ Pipe ❑ Cigars How many packs? _____/day
How many years?_____

❑ Chewing Tobacco

Alcohol History: (Present and/or Past):

❑ Non Drinker

❑ Beer	number of bottles _____per	❑ Day	❑ Week	❑ Month	
❑ Wine	number of glasses _____per	❑ Day	❑ Week	❑ Month	
❑ Liquor	number of glasses _____per	❑ Day	❑ Week	❑ Month	

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Other

Household Status: ❑ Lives Alone ❑ Lives with Family ❑ Lives in Nursing Home
❑ Winter Resident ❑ Year-Round Resident

Children: ❑ Yes ❑ No Number _____

Health Maintenance:

Sigmoidoscopy / Colonoscopy: ❑ Yes ❑ No Date:_____

Findings: _____

Last Mammogram Date: _____ Last Bone Density Date: _____Last Pelvic Exam Date:_____

Influenza (Flu) Shot Date: _____ Pneumococcal Shot Date: _____Last Shingles Shot Date: _____

Last Esophagogastroduodenoscopy (EGD) Date: _____Last Colonoscopy Date:_____

Last Prostate Exam Date: _____

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Patient Name: _____ **DOB:** _____

Review of Symptoms: (Please check any **current** symptoms you have.)

General:
- ❑ Weight Loss

How much _____
Over what time period _____
- ❑ Fevers
- ❑ Max temp _____
- ❑ Chills
- ❑ Night sweats
- ❑ Fatigue

Eyes:
- ❑ Wear Glasses/Contact Lenses
- ❑ Blurred Vision
- ❑ Double Vision

Ears, Nose, Throat:
- ❑ Hard of Hearing or Deaf
- ❑ Ringing in Ears
- ❑ Enlarged Lymph nodes
- ❑ Chronic Sinus Problems
- ❑ Sore Throat
- ❑ Mouth Pain/Sores

Changes/Difficulty In:
- ❑ Taste
- ❑ Smell

Cardiovascular:
- ❑ Chest Pain/Angina Pectoris
- ❑ Palpitations/Heart Murmur
- ❑ Irregular Heart Beat/Pressure

Respiratory:
- ❑ Chronic or Frequent Cough
- ❑ Bloody Sputum
- ❑ Shortness of Breath

Skin:
- ❑ Rashes or Itching
- ❑ Change in Skin Color or Moles
- ❑ Varicose Veins
- ❑ Skin Cancer

Gastrointestinal:
- ❑ Difficult or Painful Swallowing
- ❑ Abdominal Pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn
- ❑ Indigestion
- ❑ Lump or Sensation in Throat
- ❑ Food Sticking
- ❑ Bloating
- ❑ Belching
- ❑ Diarrhea
- ❑ Constipation
- ❑ Rectal Bleeding
- ❑ Black or Tarry Stool
- ❑ Hidden Blood in Stool
- ❑ Excessive Rectal Gas/Flatus
- ❑ Loss of Stool/Fecal Accident
- ❑ Poor Appetite
- ❑ Jaundice

Genitourinary:
- ❑ Kidney Stones
- ❑ Pelvic Pain
- ❑ Incontinence
- ❑ Burning or Pain on Urination
- ❑ Blood in Urine
- ❑ Difficult Urination
- ❑ Men: Prostate Problems

Musculoskeletal:
- ❑ Joint Pain/Arthritis
- ❑ Muscle or Joint Weakness
- ❑ Back Pain
- ❑ Bone Pain
- ❑ Muscle Aches

Neurological:
- ❑ Numbness/Tingling
- ❑ Arm or Leg Weakness
- ❑ Light-Headed/Dizzy/Fainting Spells
- ❑ Tremors/Headaches

Psychiatric:
- ❑ Anxiety/Agitation
- ❑ Depression
- ❑ Crying for No Reason
- ❑ Insomnia
- ❑ Alcoholism
- ❑ Drug Problem

Hematologic:
- ❑ Easy Bruising
- ❑ Gum or Nose Bleeding
- ❑ Blood Transfusions

Endocrine:
- ❑ Heat or Cold Intolerance
- ❑ Excessive Skin Dryness
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Weight Problem
- ❑ Hot Flashes

Breast:
- ❑ Rashes or Itching
- ❑ Changes in Skin Color
- ❑ Varicose Veins
- ❑ Skin Cancer
- ❑ Breast Pain/Lump
- ❑ Breast Discharge
- ❑ Breast Rash

Allergies/Immunology:
- ❑ History of Allergies
- ❑ Chronic Infections

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Patient Name: _____ **DOB:** _____

Check the boxes below based on your personal and family history of cancer. Leave blank what you do not know. Relatives to consider: parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:

Ashkenazi Jewish ancestry?	❑ Yes	❑ No
Breast, ovarian, pancreatic cancer or metastatic prostate cancer diagnosed at any age?	❑ Yes	❑ No
If breast cancer, HER2 negative disease?	❑ Yes	❑ No
Colorectal or uterine (endometrial) cancer diagnosed at age 64 or younger?	❑ Yes	❑ No
OR, MSI high?	❑ Yes	❑ No
OR, Abnormal IHC?	❑ Yes	❑ No
20 or more colon/rectal polyps in your lifetime?	❑ Yes	❑ No

Do you have a family history of:

Breast cancer diagnosed at age 49 or younger?	❑ Yes	❑ No
Ovarian cancer diagnosed at any age?	❑ Yes	❑ No
Pancreatic cancer diagnosed at any age?	❑ Yes	❑ No
Uterine cancer diagnosed at age 49 or younger?	❑ Yes	❑ No
Colorectal cancer diagnosed at age 49 or younger?	❑ Yes	❑ No
Metastatic prostate cancer diagnosed at any age?	❑ Yes	❑ No

MEDICATION LIST

Your treatment can be affected by any medication that you take, and it is important that your physician has updated and correct information.

Drug Allergies: List all medication allergies

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

Are you allergic to:

❑ Iodine ❑ Latex ❑ Shellfish ❑ CT Scan Dye / IV Contrast ❑ Eggs ❑ Peanuts

Other: _____

Type of Reaction: _____

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Patient Name: _____ **DOB:** _____

CURRENT MEDICATION LIST

List all medications (including non-prescription) that you are currently taking:

Medication	Dose	Frequency	Ordering Physician

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AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED FOR ELECTRONIC MEDICAL RECORDS

I authorize Edwards Cancer Center to take my photograph (digital camera/video may be used). These photos may then be placed in my electronic medical record for identification purposes and/or medical documentation.

By signing this, I verify that I have received a copy of this authorization form for my records.

_____

Patient Name (Print)

_____

Patient or Guarantor (Signature)

_____

Date

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REQUEST FOR RELEASE OF RECORDS

I, _____ , request a copy of my complete medical record from the office of:

_____

_____

Include name and address of practitioner

To be sent to Edwards Cancer Center: *(Internal use)*

_____

Address, City, State, Zip Code

_____

Fax/Telephone Number

_____ I give permission to release my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

It is my understanding that by signing this authorization for release of my records, I am giving permission for Edwards Cancer Center to receive copies of any medical, psychiatric, AIDS, AIDS-related syndromes, HIV testing, alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent is valid indefinitely until there is written communication received to revoke.

_____DISCLAIMER: Not signing does not prevent me from receiving care.

_____ _____

Patient Name (Print) Date

_____

Patient Date of Birth

_____ _____

Patient or Guarantor (Signature) Date

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CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ **DOB:**_____

Please check one of the following:

_____ **I give permission to the employees of Edwards Cancer Center to disclose my Protected Health Information to me and the following individual(s):**

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

_____ I request that all my Protected Health Information be disclosed ONLY to me and no other **individual(s)**.

I understand that I may revoke or change this Consent at any time by filling out another Consent form to replace this one.

_____ _____
Patient Name (Print) Date

_____
Patient or Guarantor (Signature)

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Patient Name: _____ **DOB:**_____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Name of primary policy holder: _____

Policy#/Group ID: _____

Policy holder's date of birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Does plan have prescription coverage? ❑ Yes ❑ No

Secondary Insurance Carrier:_____

Name of secondary policy holder: _____

Policy#/Group ID: _____

Policy holder's date of birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Does plan have prescription coverage? ❑ Yes ❑ No

Pharmacy Insurance Carrier: _____

Name of pharmacy policy holder:_____

Policy#/Bin# _____

I certify that the information provided is accurate. I will notify Edwards Cancer Center, of any changes as soon as they become available. I understand that it is my responsibility to update the practice of any changes to my insurance plan or I may be held liable for the full balance of my treatment.

_____ _____
Patient Name (Print) Date

_____
Patient or Guarantor (Signature)