

# ONCOLOGY SPECIALISTS OF CHARLOTTE, PA

## Patient Medical History

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Primary Care MD: \_\_\_\_\_ Referring MD: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

### MEDICATIONS/ALLERGIES/HT/WT

Please list any allergies and adverse reactions to medication: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs/kg

Please list ALL medications you are taking, prescription and over the counter. Include dosage and frequency:  
(If space is limited, you may provide us with a copy of a list of your medications)

Name of Medication	Dosage (ex: 10mg)	How often do you take it?

### SOCIAL HISTORY

Marital Status: \_\_\_Single \_\_\_Married \_\_\_Divorced \_\_\_Widowed  
Current occupation: \_\_\_\_\_ How long? \_\_\_\_\_ Prior occupations? \_\_\_\_\_  
Any exposure to toxins such as asbestos? \_\_\_\_\_  
Who lives with you? \_\_\_\_\_ Number of children: \_\_\_\_\_  
Do you exercise? \_\_\_Yes \_\_\_No If yes, what type and how often? \_\_\_\_\_  
Cigarettes: Have you ever smoked? \_\_\_Yes \_\_\_No If yes, when did you start? \_\_\_\_\_  
How much do you or did you smoke? \_\_\_\_\_ Pack per day Have you stopped? \_\_\_Yes \_\_\_No  
If yes, when did you stop? \_\_\_\_\_ Other tobacco: \_\_\_Pipe \_\_\_Cigars \_\_\_Snuff \_\_\_Chew  
Alcohol use: \_\_\_Yes \_\_\_No If yes, how many drinks per week? \_\_\_\_\_  
Illegal drug use: \_\_\_Yes \_\_\_No If yes, explain: \_\_\_\_\_

### IMMUNIZATIONS

Pneumonia \_\_\_Yes \_\_\_No If yes, when? \_\_\_\_\_ Flu shot \_\_\_Yes \_\_\_No If yes, when? \_\_\_\_\_  
Hep B \_\_\_Yes \_\_\_No If yes, when? \_\_\_\_\_ Tetanus \_\_\_Yes \_\_\_No If yes, when? \_\_\_\_\_

### FAMILY HISTORY

Living Age	Deceased Age and Cause	Do any of the following medical conditions run in your family? (circle) Heart Disease Diabetes Cancer Bleeding disorders Any others? _____
Mother _____	_____	
Father _____	_____	
Brother(s) _____	_____	
Sister(s) _____	_____	

### LIVING WILL/ HCPOA

Do you have a living will? \_\_\_Yes \_\_\_No If yes, please provide us a copy  
Do you have a Healthcare Power of Attorney? \_\_\_Yes \_\_\_No If yes, Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**REVIEW OF SYSTEMS**

Please indicate if you HAVE or ever HAD any of the following (please  if current):

Yes No

Yes No

Yes No

**GENERAL:**

- \_\_ Weight loss
- \_\_ Weight gain
- \_\_ Fever
- \_\_ Night sweats
- \_\_ Excessive Fatigue

**EYES:**

- \_\_ Blindness
- \_\_ Double vision
- \_\_ Blurry vision
- \_\_ Glaucoma/Cataracts

**EARS/NOSE/MOUTH:**

- \_\_ Decreased hearing
- \_\_ Ringing in ears
- \_\_ Sores of mouth/tongue
- \_\_ Difficulty swallowing

**CARDIOVASCULAR:**

- \_\_ Chest Pain
- \_\_ Shortness of Breath
- \_\_ Palpitations/skipped beats
- \_\_ Previous heart attack
- \_\_ Congestive Heart Failure
- \_\_ Ankle swelling

**RESPIRATORY:**

- \_\_ Cough
- \_\_ Asthma
- \_\_ Emphysema

**SKIN:**

- \_\_ Rash
- \_\_ Unusual mole

**GASTROINTESTINAL:**

- \_\_ Nausea or Vomiting
- \_\_ Diarrhea
- \_\_ Constipation
- \_\_ Blood in stool
- \_\_ Ulcers
- \_\_ Liver problems

**GENETOURINARY:**

- \_\_ Kidney Stones
- \_\_ Burning with urination
- \_\_ Blood in urine
- \_\_ Incontinence
- \_\_ Difficulty with urination

**MUSCULOSKELETAL:**

- \_\_ Muscle weakness
- \_\_ Joint pain
- \_\_ Arthritis

**NEUROLOGICAL:**

- \_\_ Stroke or paralysis
- \_\_ Seizures
- \_\_ Dizziness or fainting

**PSYCHIATRIC:**

- \_\_ Anxiety attacks
- \_\_ Depression
- \_\_ Nervous breakdown

**IMMUNOLOGIC:**

- \_\_ Hay Fever
- \_\_ Shingles
- \_\_ Chicken Pox
- \_\_ HIV or AIDS

**ENDOCRINE:**

- \_\_ Lump or mass in neck
- \_\_ Thyroid problems
- \_\_ Other glandular problems

**BREAST:**

- \_\_ Mass or lump
- \_\_ Discharge
- \_\_ Pain

**HEMATOLOGIC:**

- \_\_ Unusual bleeding/bruising
- \_\_ Anemia
- \_\_ Swollen lymph nodes
- \_\_ Sickle cell trait

**GYNOCOLOGIC(female):**

- \_\_ Menopause
- If no, Date of LMP \_\_\_\_\_
- \_\_ History of birth control pills
- \_\_ History of hormone pills
- # of pregnancies: \_\_\_\_\_
- # of children: \_\_\_\_\_

**CANCER:**

- \_\_ History of cancer
- If yes, what type and when?  
\_\_\_\_\_
- \_\_\_\_\_
- \_\_ Any other conditions?  
\_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**PREVIOUS SURGICAL PROCEDURES**

Type	Date	Reason	Surgeon (if known)

**EMERGENCY CONTACT(S)**

Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not patient, Name and Relationship: \_\_\_\_\_