Patient Medical History

HUNTSMAN CANCER INSTITUTE, UNIVERSITY OF UTAH — HEALTH, UNIVERSITY OF UTAH

CLINIC STAFF
This form will be scanned into the electronic medical record. DO NOT REMOVE IT FROM THE CLINIC.

Please answer these medical and personal history questions as completely as possible.

Last name ______________ First name ______________ Date of birth ______________

Name you go by ______________ Best phone number to reach you ______________

May we leave messages from Huntsman Cancer Institute (HCI) at that number? Yes _____ No _____

In what city do you live? ______________ With whom do you live? ______________

Do you have to make special travel arrangements to get to HCI? Yes _____ No _____

Doctors You Have Seen

Who is your primary care doctor? ______________

What is the best phone number to reach your primary care doctor? ______________

Are there other doctors you see regularly that we should send notes to?

Doctor ______________ Phone ______________

Doctor ______________ Phone ______________

Doctor ______________ Phone ______________

Which doctor sent you to HCI? ______________

What is your main concern today? ______________

Medical History

Please check all conditions with which you have ever been diagnosed.

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding problems
- ☐ Cancer
- ☐ Circulatory problems
- ☐ Colon problems
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Heart attack
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Lung problems
- ☐ Lupus
- ☐ Nerve problems or neuropathy
- ☐ Rheumatoid arthritis
- ☐ Scleroderma
- ☐ Sleep apnea
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Other ______________
- ☐ Other ______________

continued on page 2

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Surgical History Please list all past surgeries and dates.

Have you had anesthesia? Yes _____ No _____ Did you have problems with anesthesia? Yes _____ No _____

If Yes, please check the problems:

☐ Nausea or vomiting ☐ Trouble placing the breathing tube ☐ Difficulty waking up ☐ Allergic reaction

Other anesthesia problems (please explain) ____________________

[Women only] Reproductive History

At what age did you have your first period? ____________

Have you ever taken birth control pills? Yes _____ No _____ If yes, how long did you take them? ____________

Have you ever been pregnant? Yes _____ No _____ How many times? ____________

What age were you when your first child was born? ____________

Have you gone through menopause? Yes _____ No _____ If yes, at what age? ____________

Have you ever used hormones for menopause symptoms? Yes _____ No _____

If yes, how long did you use them? ____________

Have you had a hysterectomy? Yes _____ No _____ If yes, were your ovaries also removed? Yes _____ No _____

Have you had an oophorectomy (only your ovaries removed)? Yes _____ No _____

Cancer Treatment History, including radiation and chemotherapy

Treatment Type	Treatment Date and Duration	Where Treatment Was Done	Details

Other Medical History Please list other problems and hospitalizations not shown above.

____

____

____

____

continued on page 3

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Last name ______________________ First name ____________________ Date of birth ____________

Medications
Please list all medicines you now take, including supplements, herbs, and over-the-counter products.

Name of Medicine	Dose *(for example, 10 mg)*	Route *(for example, by mouth, injection, or IV)*	How Often You Take It *(for example, every 4 hours)*

Immunizations
When did you last have these vaccinations?

Influenza (flu shot) Date ____________

Pneumonia Date ____________

DPT (diphtheria, pertussis, tetanus) Date ____________

Chickenpox Date ____________

MMR (measles, mumps, rubella) Date ____________

Other Medication Questions

Have you recently *stopped* taking any of these medicines?

Aspirin Date ____________

Warfarin/Coumadin Date ____________

Other blood-thinner Date ____________

Name of other blood thinner ______________________________

When was your last tuberculosis test? Date ______________

Have you taken steroids such as prednisone, dexamethasone (decadron) or hydrocortisone (cortisol) in the last 6 months?

Yes _____ No _____

Allergies
Please list anything you are allergic to and mark your reaction to it.

Allergy	Date of Reaction	Rash or Hives	Face or Neck Swelling	Itching	Difficult Breathing	Other Reaction (please describe)

continued on page 4

Social History

Tobacco

Have you ever used tobacco products including cigarettes, pipe, cigars, chew, or snuff? Yes _____ No _____

How many cigarettes/pipes/cigars/chews/snuff do/did you use each day? _________ How long have you used it? _________

If you quit tobacco, how long did you use it? ____________ When did you stop? ____________

Alcohol

Do you drink alcohol? Yes _____ No _____ If yes, how often do you use it? Circle your response.

3 drinks/week or less 1 drink/day 2 drinks/day 3 drinks/day More than 6 drinks/day

Do you use injected or intravenous drugs without a doctor's prescription? Yes _____ No _____ Yes, but quit _____

Does anyone hurt, hit, or threaten you? Yes _____ No _____

Have you completed an advance directive? Yes _____ No _____

Have you ever served in the military? Yes _____ No _____

Have you ever been exposed to chemicals or radiation that could cause cancer? Yes _____ No _____ I don't know _____

Do you use a seat belt whenever you are in a car? Yes _____ No _____

What is your marital status? Married ___ Divorced ___ Separated ___ Cohabiting ___ Widowed ___ Single ___

Do you have a religious preference? If yes, what is it? ________________________________

What support systems can you and your family count on? (Mark all that apply.)

☐ Extended family ☐ Friends and neighbors ☐ Church ☐ Other (please list) ________________________

What is your occupation? If you are retired, what work did you do? ________________________

How far did you go in school? ________________________

What are your hobbies and interests? ________________________

Family Medical History

How many sisters do you have? _________ Brothers? _________ Daughters? _________ Sons? _________

On the chart below, please mark relatives who have been diagnosed with the diseases listed.

Disease	Mother	Father	Sibling	Child	Grand-parent	Other	More Information
Cancer							Age at diagnosis and cancer type
Diabetes							Diagnosed in childhood or adult?
Heart disease							Age when diagnosed:
Stroke							Age when diagnosed:
Blood clot							
Bleeding disorder							

continued on page 5

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Last name ______________ First name ______________ Date of birth ____________

Please list other health problems in your relatives you would like us to know about.

____

____

Review of Systems

How is your overall health? Good _______ Fair _______ Poor _______

How much exercise can you do? Please mark the best description for you.

☐ Vigorous *(jogging)*	☐ Moderate *(fast walk)*	☐ Light *(slow walk)*	☐ Minimal *(walk with or without aid)*	☐ None

Please mark all the conditions below that you have had **in the past month**.

General
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight change (in past 6 months) ______________

Bladder and Genitals
- ☐ Blood in urine
- ☐ Difficult urination
- ☐ Frequent urination
- ☐ Inability to control urination
- ☐ Painful urination

Blood
- ☐ Bleed a lot
- ☐ Bruise easily

Emotions and Moods
- ☐ Anxiety or nervousness
- ☐ Depression
- ☐ Difficulty falling or staying asleep
- ☐ Hallucinations
- ☐ Thoughts of harming yourself

Head, Eyes, Ears, Nose, and Throat
- ☐ Difficulty swallowing
- ☐ Double or blurred vision
- ☐ Earache
- ☐ Hearing problems
- ☐ Lumps in neck
- ☐ Mouth sores
- ☐ Nosebleed
- ☐ Sinus problems
- ☐ Sore throat

Do you wear glasses or contact lenses?
Yes _____ No _____

Do you wear dentures?
Yes _____ No _____

Heart
- ☐ Chest pain
- ☐ Heartbeat irregular
- ☐ Heartbeat rapid
- ☐ Pain in feet
- ☐ Swollen legs (edema)

Do you have a pacemaker?
Yes _____ No _____

Do you have a defibrillator?
Yes _____ No _____

Hormones
- ☐ Change in nails
- ☐ Dry skin
- ☐ Excess hair
- ☐ Hair loss
- ☐ Inability to tolerate heat or cold
- ☐ Night sweats

Lungs
- ☐ Cough, dry
- ☐ Cough, wet
- ☐ Cough, with blood
- ☐ Difficulty breathing

Do you use oxygen at home?
Yes _____ No _____

Muscles and Bones
- ☐ Back pain
- ☐ Difficulty walking
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Muscle pain or cramps
- ☐ Muscle weakness
- ☐ Other pain ______________

Nervous System
- ☐ Balance problems
- ☐ Burning or prickling
- ☐ Dizziness
- ☐ Headaches
- ☐ Muscle weakness
- ☐ Shaking

Reproductive
- ☐ Heavy periods
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Sexual function problems

Stomach and Intestines
- ☐ Belly pain
- ☐ Constipation
- ☐ Cramping
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Red, bloody stool
- ☐ Tarry, black stool
- ☐ Vomiting, especially with blood

continued on page 6

Can you currently do these things?

Activity		If No, could you do this before your illness?
Dress yourself	Yes _____ No _____	Yes _____ No _____
Balance a checkbook	Yes _____ No _____	Yes _____ No _____
Feed yourself without help	Yes _____ No _____	Yes _____ No _____
Drive	Yes _____ No _____	Yes _____ No _____
Use the toilet without help	Yes _____ No _____	Yes _____ No _____
Ride a bus or train	Yes _____ No _____	Yes _____ No _____
Walk without help	Yes _____ No _____	Yes _____ No _____
Walk up a flight of stairs	Yes _____ No _____	Yes _____ No _____
Prepare a meal for yourself	Yes _____ No _____	Yes _____ No _____
Keep track of your medicines	Yes _____ No _____	Yes _____ No _____
Do your own shopping	Yes _____ No _____	Yes _____ No _____