Patient Name:______________________________________

Northwest Georgia Oncology Centers, P.C.
"For the care of cancer and blood disorders"

MEDICAL RECORD # ______________________________
DATE: ____
DOB: __________________________ AGE: ______________

REFERRING DOCTOR:______________________________
OTHER DOCTORS YOU SEE: _________________________
____

REASON FOR VISIT:
____
____

PAST HISTORY:

1. MEDICAL:

	No?	Yes?	Date of Diagnosis	Treated?	Describe
High Blood Pressure					
Heart Disease:					
Blocked vessels (coronary artery disease)					
Heart attack (myocardial infarction)					
Heart valve problems					
Congestive heart failure					
Rhythm problems (fast, slow, irregular)					
High cholesterol/triglycerides					
Thyroid problems:					
Too active					
Too low					
Diabetes					
Asthma					
Migraines					
Gout					
Kidney problems:					
Stones					
Poor function or failure					
Stomach/intestinal ulcers					
Arthritis					
Seizures					
Other prior history of cancer					
HIV					
Hepatitis A					
Hepatitis B					
Hepatitis C					
Osteoporosis					
Reflux (GERD)					

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2. SURGICAL:

	Yes?	Year	Where	Surgeon	Describe
Appendix					
Gallbladder					
Tonsils					
Uterus					
Ovaries (One)					
Ovaries (Both)					
Spleen					
Breast (Partial)					
Breast (Complete)					
Stomach					
Colon (Partial)					
Colon (Complete)					
Heart (Stent)					
Heart (Angioplasty)					
Heart (Bypass/CABG)					
Heart (Valve replacement)					
Heart (Pacemaker)					
Heart (Defibrillator)					
Joint Replacement (Hip)					
Joint Replacement (Knee)					
Inguinal Hernia Repair					
Cataract Surgery (Right)					
Cataract Surgery (Left)					
Cataract Surgery (Both)					

Procedures (Health Maintenance):

When was your last:

Chest X-ray ______________

Colonoscopy ______________

Eye exam ______________

Rectal exam ______________

Pelvic exam ______________

Pneumonia vaccine ______________

Prostate exam ______________

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PROCEDURES (Other): Have you ever been hospitalized, other than for surgery?

Why	Where	When

3. GYNECOLOGIC HISTORY:

Total Pregnancies (Gravida?) ________ # Live births (Para)? ________ # Abortions? ________

First menstrual period (menses start) age? ________ Last menstrual period (menopause) age? ________

Birth control pills (OCP) Yes ________ No ________ Current birth control method? ________

Hormone replacement therapy (post-menopause use)? Yes ________ No ________

Last Mammogram? _____________________ Last PAP Smear? _____________________

4. PRESENT MEDICATIONS (Please include prescription and over-the-counter medications):

Name	Start Date	Dose	Frequency	Duration	Reason

5. ALLERGIES:

Do you have any known allergies? Yes ____ No ____

If Yes, please list any allergies to foods or medications using tables below. For each allergy listed, circle any reactions and the severity of each (Low, Medium or High).

Allergy: ____

Reaction:	Rash/Hives	Shock	Trouble Breathing	Nausea/Diarrhea	Anemia	_____________
Severity:	L M H	L M H	L M H	L M H	L M H	L M H

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Allergy: ____

Reaction:	Rash/Hives	Shock	Trouble Breathing	Nausea/Diarrhea	Anemia	____________
Severity:	L M H	L M H	L M H	L M H	L M H	L M H

Allergy: ____

Reaction:	Rash/Hives	Shock	Trouble Breathing	Nausea/Diarrhea	Anemia	____________
Severity:	L M H	L M H	L M H	L M H	L M H	L M H

Allergy: ____

Reaction:	Rash/Hives	Shock	Trouble Breathing	Nausea/Diarrhea	Anemia	____________
Severity:	L M H	L M H	L M H	L M H	L M H	L M H

Allergy: ____

Reaction:	Rash/Hives	Shock	Trouble Breathing	Nausea/Diarrhea	Anemia	____________
Severity:	L M H	L M H	L M H	L M H	L M H	L M H

6. FAMILY HISTORY:

Family Member	Alive	Deceased	Age	List Illnesses or Cause of Death
Mother				
Father				
Siblings (brothers/sisters)				
Other:				

7. SOCIAL HISTORY:

Have you ever smoked cigarettes?

- ☐ Never
- ☐ Less than 100 cigarettes
- ☐ Yes,
  - Year Started: ______________
  - Average # Packs / day ________
  - Year Quit: ________________

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Do you / have you used other tobacco products?

- ☐ Pipe
- ☐ Cigar
- ☐ Oral tobacco

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Do you drink alcohol? Yes ____ No ____Occasionally ____ Quit ____
How many drinks a day do / did you drink? ____ # Yrs Quit ____
How many days a week do /did you drink? ____

Do you have a history of sunburn / sunbathing? None ____ Some ____ A Lot ____
Do you use recreational drugs? Yes ____ No ____

Personal / Environment:
Marital Status: Divorced Life Partner Married Single Widowed
Occupation: ____

8. SYMPTOMS Check if you have any of these symptoms:

	Symptom	✓	Date of Onset
783.21	Significant weight loss		
783.1	Significant weight gain		
784.0	Frequent headaches		
368.10	Visual changes		
786.05	Shortness of breath		
729.81	Ankle swelling		
786.2	Cough		
786.59	Chest Pain		
787.1	Heartburn		
787.02	Nausea alone		
787.01	Nausea with Vomiting		
787.20	Swallowing Problems		
786.30	Coughing up blood		
	Other:		

	Symptom	✓	Date of Onset
780.94	Early fullness when eating		
787.91	Diarrhea		
564.00	Constipation		
578.1	Blood in stool		
788.41	Urinary frequency		
788.1	Urinary burning		
599.70	Blood in urine		
782.1	Rash		
780.60	Fever		
780.8	Sweats		
733.90	Bone pains		
719.40	Joint pains		
	Other pain		
	Other:		

7. Do you have any of the following:

	Copy Obtained for Chart	
☐ Living Will	☐ Yes	☐ No
☐ Durable Healthcare Power of Attorney	☐ Yes	☐ No
☐ Advance Directives	☐ Yes	☐ No

IF YES, PLEASE BRING A COPY OF IT TO THE OFFICE AT YOUR NEXT VISIT.

10. COMMENTS:
____
____
____
____
____
____
____