SURGICAL ONCOLOGY ASSOCIATES OF SOUTH TEXAS

The below information has been confirmed and reviewed verbally with the patient:

_____

Physician signature *Date*

Name: _____Date: _____

What problem brings you to our clinic today? When did it start? Are you having symptoms? Have you started medications / treatment for this problem?

_____

_____

_____

Past History: (circle those that apply to you)

CONSTITUTIONAL: changes in weight, appetite, sleep, mood, energy level

HEAD AND NECK: headache, blurred vision, double vision, painful swallowing, frequent choking on foods, neck pain / stiffness, neck masses, loss of consciousness, seizures

RESPIRATORY: dry cough, productive cough, shortness of breath at rest or with little exertion, chest pain when you breathe in, vomiting blood, coughing up blood, awakening at night with shortness of breath, asthma

CARDIOVASCULAR: high blood pressure, chest pain at rest, chest pain with exertion, heart racing, irregular heartbeat, blood clots, heart disease, vascular problems, swelling in legs, ankle, or feet, stroke, or heart attack

GASTROINTESTINAL: constipation, diarrhea, abdominal pain, gall bladder disease, Gall bladder removed, stomach ulcers, change in quality of stools, blood in stool, hemorrhoids, rectal pain, indigestion, nausea, vomiting, weight loss? weight gain? how much #??____ in what amount of time?? _____ was this purposeful???___ diabetes

GENITOURINARY: pain with urination, incomplete emptying of bladder, blood in urine, incontinence, kidney stones, sexual transmitted disease, trouble starting or stopping stream, awakening at night to urinate.

GYNECOLOGIC: see below under “FEMALE ONLY”

BREASTS: abnormal mammogram, diagnoses of breast cancer, fibrocystic disease of the breast, nipple discharge, pain, tenderness, redness, swelling, pain under your arm

NEUROMUSCULAR: dizziness, numbness, tingling, fainting spells, seizures, back pain, joint swelling, decrease range of motion, shooting pains down legs, any broken bones in the past, arthritis

SKIN: skin cancer in the past, rash, bruises easily, dryness, non-healing sores / lesions

LYMPH / HEME: anemia, difficulty clotting blood, history of blood clot, swollen / enlarged lymph nodes, blood transfusion in the past, reaction to a blood transfusion

PSYCHOLOGIC: unable to sleep, anxiety, depression, drug or alcohol problems, nervous breakdown, admission to a hospital for altered mood

Are there any other medical problems not listed above that you feel we should know about??

_____
_____
_____
_____

OPERATIONS / HOSPITALIZATIONS / PROCEDURES

Problem(s)	Year

Have you ever had a problem with general anesthesia? [] yes [] no
If yes, please describe:_____

Prior history of cancer: [] Yes [] No if yes, describe: _____
Prior radiation therapy: [] Yes [] No if yes, describe: _____

PERSONAL HISTORY / DEMOGRAPHICS:
Birth date: _____ Birthplace: _____
Highest Education: _____
Occupation: _____
Do you have a support person? _____
Who is your support person? _____
Age of Spouse/Partner/Support Person? _____
Health of Spouse/Partner/Support Person? _____
Children:
Number of Children:_____ Age:_____Sex:_____

List Medications / Herbals / Over-the-Counter Drugs / Vitamins taken on a regular basis:

_____
_____
_____
_____

Allergies: _____
Illicit Drug History: _____
Social Habits:
___cigarettes/day ____cigars/day ___lbs. chewing tobacco/week
___ drinks of alcohol / day
Other: _____

FEMALE ONLY:
When did you first menstruate ____
When did you stop menstruating?
Cycle-Every ___ days. Last MP___
Have you ever been treated for an abnormal pap smear? [] yes []no
Date of last pap smear?_____
Excessive or scanty bleeding?____
Number of pregnancies ____
Number of children _____
Number of miscarriages _____
Number of abortions _____
Weight of largest baby at birth _____
Have you ever had a pelvic infection? [] yes [] no
Have you ever had a sexual transmitted disease? [] yes [] no
Do you practice monthly self-breast exams? [] yes [] no
Date of last mammogram: _____

FAMILY HISTORY OF CANCER:
[] I am adopted and have no record of family history
[] I have no sisters and my mother has no sisters
[] I have no family history

Family member #1_____(ie: aunt, mother, uncle)
Type of Cancer _____(ie: colon, breast, brain)
[] Maternal or [] Paternal
[] alive and well [] alive with disease
[] deceased of disease [] deceased of other cause

Family member #2_____
Type of Cancer _____
[] Maternal or [] Paternal
[] alive and well [] alive with disease
[] deceased of disease [] deceased of other cause

Family member #3_____
Type of Cancer _____
[] Maternal or [] Paternal
[] alive and well [] alive with disease
[] deceased of disease [] deceased of other cause

FAMILY ILLNESSES:

[] Diabetes	[] Arthritis and/or gout
[] Kidney disease	[] Heart attacks
[] High blood pressure	[] Asthma
[] Rheumatic fever	[] Stroke
[] Bleeding tendency	[] Alcoholism
[] Tuberculosis	[] Nervous breakdown