Methodist Richardson Hematology Oncology Associates

COMPREHENSIVE PATIENT MEDICAL HISTORY FORM

Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or date. Thank you!

PERSONAL INFORMATION:

Preferred Name:______________________________ DOB:____________ Date:____________

Current Health Concerns:______________________________

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MEDICATIONS: (Prescription and non-prescription medications, vitamins, birth control pills, herbs and supplements.)

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

Drug Allergies or Reactions to Medications / Foods / Other Agents: ☐ Yes ☐ No Please list:

____

____

PERSONAL MEDICAL HISTORY: Do you have any of the following?

☐ Acid Reflux (heartburn)
☐ Alcoholism
☐ Allergies (environmental)
☐ Anxiety
☐ Asthma
☐ Atrial Fibrillation
☐ Cancer (list below)
☐ Cholesterol Problem
☐ Coagulation (bleeding) Problem
☐ Chronic Low Back Pain
☐ Depression
☐ Diabetes
☐ Erectile Dysfunction
☐ Gout
☐ High Blood Pressure
☐ Heart Disease (explain below)
☐ Migraines
☐ Osteopenia / Osteoporosis
☐ Prostate Problems
☐ Thyroid Problems
☐ Other Chronic or Recurring Medical Problems (Please list below)

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Patient Name:______________________________ Date: ______________

PRIOR SURGERIES AND HOSPITALIZATIONS: ☐ Yes ☐ No (Please list all prior operations and hospitalizations)

DATE	SURGERY OR HOSPITALIZATION	DATE	SURGERY OR HOSPITALIZATION

Have you received a blood transfusion? ☐ Yes ☐ No When? ______________________________

FAMILY HISTORY: Please indicate with a check any family members who have had any of the following conditions:

Check here if you don't know your family history ☐

MEDICAL CONDITION	MOM	DAD	BRO	SIS	DAUG	SON	OTHER CLOSE RELATIVES	MEDICAL CONDITION	MOM	DAD	BRO	SIS	DAUG	SON	OTHER CLOSE RELATIVES
Alcoholism								Genetic Diseases							
Anemia								Glaucoma							
Anesthesia Problem								Allergies							
Arthritis								High Cholesterol							
Asthma								Heart Disease (Heart attack, stent or bypass surgery)							
Birth Defects								High Blood Pressure							
Cancer, Breast								Kidney Disease							
Cancer, Colon								Migraine Headaches							
Cancer, Melanoma								Osteoporosis							
Cancer, Other Skin								Rheumatoid Arthritis							
Cancer, Ovary								Seizures							
Cancer, Prostate								Strokes							
Cancer (other list below)								Thyroid Disorders							
Colon Polyps								Tuberculosis							
Depression								Other:							
Diabetes, Type 1															
Diabetes, Type 2															

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COMPREHENSIVE PATIENT MEDICAL HISTORY FORM

Patient Name:____ Date: ____________________

SOCIAL HISTORY:

Tobacco Use

Please check one

☐ I have never smoked

☐ I have smoked, but rarely

When was the last time?____________________

☐ I have quit smoking. Quit Date:______________

How many packs/day?_____ How many yrs?_____

☐ I currently smoke______pack(s)/day.

How many yrs.________

Other Tobacco: ☐ pipe ☐ cigar ☐ snuff ☐ chew

Are you interested in quitting? ☐ Y ☐ N

Alcohol Use

Do you drink alcohol? ☐ Y ☐ N

☐ never ☐ occasionally ☐ regularly

Average # drinks/week? 5 oz. wine_______

12 oz. beer______ 1.5 oz. hard liquor______

Is alcohol use a concern for you or others? ☐ Y ☐ N

Drug Use

Do you use recreational drugs? ☐ Y ☐ N

Have you ever used needles? ☐ Y ☐ N

Sexual History

Are you sexually active? ☐ Y ☐ N ☐ Not currently

Current sexual partner(s) is/are ☐ male ☐ female

Birth control method:________________________

Have you ever had any sexually transmitted diseases (STD's)? ☐ Y ☐ N Date:__________ Which STD?____________

Are you interested in being screened for sexually transmitted diseases? ☐ Y ☐ N

Exercise

Do you exercise? ☐ Y ☐ N How often? ☐ Daily ☐ 4 – 6x a week ☐ 1 – 3x a week ☐ less than one time a week

What form of exercise? (e.g., jogging, cycling, swimming) ________________________________

Safety

Do you use seat belts consistently? ☐ Y ☐ N

Is violence at home a concern for you? ☐ Y ☐ N

Are you currently in a relationship? ☐ Y ☐ N

If yes, do you feel safe in this relationship? ☐ Y ☐ N

Other concerns?____________________________

Socioeconomics

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widow

Occupation:____

Education completed: ☐ grade school ☐ high school ☐ college ☐ graduate school

Number of children:________ Who lives at home with you?______________________________

Frequent foreign travel? ☐ Y ☐ N Where?__________________________________

Patient Name:______________________________ Date: ________________

Immunizations: Please check any immunizations you were given and your best estimate of the month and year it was given.

Tetanus: ☐ Y ☐ N_______ Pneumonia: ☐ Y ☐ N_______ Chicken Pox: ☐ Y ☐ N_______ Hepatitis A: ☐ Y ☐ N_______

Hepatitis B: ☐ Y ☐ N_______ HPV (genital warts): ☐ Y ☐ N_______ Shingles: ☐ Y ☐ N_______

REVIEW OF SYSTEMS (please circle any *CURRENT* problems you have on the list below)

General
- Fatigue / Weakness
- Restless Sleep
- Daytime Drowsiness
- Unhappiness
- Depression / Sadness
- Feeling "Blue" or Hopeless for More than 2 wks
- Lack of Motivation
- Excessive Irritability
- Feelings of Worthlessness
- Nervous / Anxiety
- Unexplained Fever (> 100.0)
- Frequent Night Sweats
- Unexplained Weight Loss
- Unexplained Weight Gain
- Excessive Thirst

Skin
- Changes in Moles / Unusual Moles
- Concerns re: skin spots / rashes / growths
- Bruise Easily
- Itching
- Excessive Hair Growth
- Hair Loss

Ears / Nose / Throat
- Allergy Symptoms
- Hearing Loss
- Ringing in the Ears
- Dizzy Spells / Dizziness
- Nose Bleeds
- Sinus Problems
- Hoarseness – Frequent

Eyes
- Eye Pain
- Double Vision / Change in Vision
- Itchy / Watery Eyes

Lungs
- Cough / Wheeze
- Snoring / Gasping at Night During Sleep
- Difficulty Breathing
- Positive TB Skin Test

Heart
- Chest Pain / Pressure
- Recent Change in Exercise Tolerance
- Heart Murmur
- Palpitations / Irregular Pulse
- Fainting Spells
- Swollen Ankles
- Leg Pain with Walking / Exercise

Gastrointestinal
- Abdominal Pain
- Heartburn / Indigestion
- Change in Bowel Habits – Recent
- Difficulty Swallowing
- Persistent Nausea / Vomiting
- Diarrhea / Constipation
- Bloody or Black Tarry Stools
- Frequent Laxative Use? How Often?

Musculoskeletal
- Muscle / Joint Pain
- Recurrent or Chronic Back Pain
- Joint Swelling
- Gout

Genitourinary
- Frequent Urine Infections
- Painful Urination
- Frequent Urination
- Urinary Leakage / Incontinence
- Blood in Urine
- Overnight Urination > 2 x
- Sexual Function Problems

Male
- Decrease in Force of Urination
- Erection Problems
- Testicle Lumps / Swelling

Female
- Vaginal Discharge / Itching
- History of Abnormal Pap Smear
- Pain / Bleeding During Sex
- Significant Pain / Cramps with Menses
- Hot Flashes / Night Sweats

Menstrual History
- Age of onset______ reg. / irreg. / menopause
- Flow: heavy / moderate / light
- Length of cycle_______ Days of flow_______
- # of pregnancies_____ # of births ________
- # of miscarriages / abortions ____________

Breast
- Pain / Lumps / Discharge

Neurological
- Frequent Headaches
- Numbness / Tingling
- Memory Loss
- Tremor / Shaking

Explanation:____