

My Medical History

Name _____ Date of birth _____

Recent cancer diagnosis _____ Date of diagnosis _____

Allergies/reaction _____

Emergency contact _____ Tel: () _____

Surgeon _____ Tel: () _____ Fax: () _____

Primary doctor _____ Tel: () _____ Fax: () _____

Medical oncologist _____ Tel: () _____ Fax: () _____

Radiation oncologist _____ Tel: () _____ Fax: () _____

Other doctor _____ Tel: () _____ Fax: () _____

Pharmacy _____ Tel: () _____ Fax: () _____

Do you have Advance Directives: No Yes kept in (location) _____

My designated agent's name and telephone number _____ () _____

Date of immunizations: Tetanus _____ TB skin test _____ Flu shot _____

Pneumonia vac _____ Hepatitis _____ Others _____

Date of tests: Mammogram _____ Bone density _____ Pelvic exam _____

Pap smear _____

Medical Problem(s) *Encircle the problem for yes answer*

Other cancer/date

Cardiovascular

- Anemia
- Bleeding easily
- Blood clots (phlebitis)
- Chest pain
- Dizzy/fainting spells
- Heart attack/failure
- High blood pressure
- Stroke

Lung

- Asthma/bronchitis
- Chronic cough
- Emphysema pneumonia
- Tuberculosis
- Did you or do you smoke
No
Yes pack/yr _____

Musculoskeletal

- Arthritis
- Bone/joint pain
- Osteoporosis

Abdomen

- Abdominal swelling
- Blood in the stool
- Constipation/diarrhea
- Gall Bladder
- Heart burn/ulcer
- Hepatitis _____
- Nausea/vomiting
- Ulcer

Bladder

- Low back pain
- Bladder infection
- Blood in the urine
- Frequent urination
- Kidney infection

Others

- Convulsion/seizure
- Diabetes
- Hypothyroidism
- Hyperthyroidism
- Leg pain/leg swelling

Anxiety/depression

Weight loss _____ lbs
Over what time period:

**Current symptoms
bothering you**

Gynecology History

Age at first menstrual period _____ Age at menopause _____ Age at first live birth _____

Number of pregnancies _____ Number of live births _____ Total months of breast feeding _____

Hysterectomy No Yes , age _____ Were ovaries removed too? No Yes

Hormone therapy: a. Birth control pills No Yes Total months/years _____

b. Estrogen No Yes Total months/years _____ c. Progesterone No Yes Total months/years _____

Past Surgeries or Invasive Procedures/Date

My Family History

Relation/Name	Living?		Medical History <i>Please circle appropriate history</i>				
	Yes (age)	No	C (cancer)	CV (heart problem)	D (diabetes)	S (stroke)	Other:
Paternal grandfather	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Paternal grandmother	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Maternal grandfather	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Maternal grandmother	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Father	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Mother	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Maternal aunt	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Maternal uncle	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Paternal aunt	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Paternal uncle	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Brother	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Brother	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Brother	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Sister	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Sister	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Sister	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
1st degree cousin	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
1st degree cousin	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
Children:	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		
	:	:	C	Type: _____	Age at diagnosis _____		
	:	:	CV	D S	Other: _____		