CAROLINA ONCOLOGY SPECIALISTS, PA
NEW PATIENT MEDICAL HISTORY

Patient Name _____ **Date** _____

List of Physicians in your care: _____

_____

_____

_____

Diagnosis or Reason for your visit today: _____

Past Medical History:
Primary Care Physician _____

Surgical: List any surgery that you have had, even if it was a long time ago such as; hysterectomy, prostate, hernia, gallbladder, breast biopsy, broken bones, etc. Include dates. _____

_____

_____

_____

_____

Medical: **List your medical conditions that you have now or in the past such as; diabetes, high blood pressure, heart attack, angina, heart failure, prostate, migraines, liver disease, emphysema, asthma, positive TB skin test, pneumonia, kidney condition, etc.** _____

_____

_____

_____

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_____

Allergies: **List the name of the drug, the type of reaction, and the severity of the reaction.** ___

_____

_____

Family History: **Please list illnesses of your blood relatives. List any cancers or blood disorders and if relatives are deceased, give cause of death and age at time of death.**
Father: Alive/deceased _____

_____

_____

Mother: Alive/deceased _____

_____

_____

Brothers: Alive/deceased _____

_____

_____

Sisters: Alive/deceased _____

_____

_____

Children: Alive/deceased _____

_____

_____

Social History:
Patient: Occupation _____
Marital Status: (Circle One) Single Married Divorced Separated Widowed
Spouse: Occupation _____

Hobbies:
_____

Alcohol Use:
Drink alcohol: Now _____**In the past** _____**How much?** _____

_____

_____

Related Problems: _____

Tobacco Use:
Cigarettes: Now : _____**Past** ____ **Cigars: Now** _____**Past** ___ **Pipe: Now** ___**Past** ___
Snuff: Now _____**Past** ___
Chewing tobacco: Now __**Past** ___ **Number of tobacco use years over lifetime?** _____
If you have quit, how long ago did you quit? _____**Why did you quit?** _____

Sexual Activity:
Are you currently, or have you previously been sexually active? Yes No
Please specify current or previous sex partner(s). Men Women Both
Have you currently, or previously had unprotected sex? Yes No
Have you ever been diagnosed with HIV or other STD(s)? Yes No

Female Only:
Are you still having menstrual periods? Yes No Are your periods regular? Yes No
If you are not having periods, then how old were you when they stopped? _____

_____

Have you had vaginal bleeding after your periods stopped? Yes No
Have you taken estrogen hormone pills? (Premarin, birth control pills) No Yes Drug: _____

_____

_____

Are you taking hormone (estrogen) pills now? Yes No Drug_____

_____

_____

How many times have you been pregnant? _____**Births:**_____**Abortions/Miscarriage:**_____

_____

Patient Signature _____**Parent/guardian if minor** _____

Date:_____