# Carolina Oncology Specialists, PA
# NEW PATIENT HISTORY

Patient Name _____ Date _____

Primary Care Physician: _____

Other Physicians involved in your care: _____

_____

**Previous Surgeries:** (List any surgery you have ever had such as; hysterectomy, prostate, hernia, gallbladder, breast biopsy, broken bones. Include date of the surgery.)

_____

_____

_____

**Conditions you have been diagnosed with:** (List all medical conditions you have now or in the past such as; diabetes, high blood pressure, heart attack, angina, heart failure, migraines, liver disease, emphysema, asthma, positive TB test, pneumonia, kidney condition.)

_____

_____

_____

**Family History:** (List medical conditions 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 or Deceased _____

Mother: Alive or Deceased _____

Brother(s): Alive or Deceased _____

Sisters(s): Alive or Deceased _____

Child(ren): Alive or Deceased _____

# Carolina Oncology Specialists, PA
# NEW PATIENT HISTORY (continued)

Occupation: _____

Marital Status: Single Married Divorced Separated Widowed

Spouse's Occupation: _____

Hobbies: _____

Alcohol Use: ___Currently ___In the Past ___Rarely/Socially ___Never

How much do (or did) you use? _____

If in the past, how long ago did you quit? _____

Tobacco Use: ___Currently ___In the Past ___Rarely/Socially ___Never

What kind? __Cigarette __Cigar __Chew/Snuff __Pipe __e-cigarette

How much do (or did) you use? _____

How long have (or did) you use?_____

If in the past, how long ago 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) ___yes ___no

If so, name of drug? _____ Still taking? ___yes ___no

How many times have you been pregnant? _____
Number of births: _____ Number of miscarriages/abortions: _____