Patient's Name: ________________________________

NEW PATIENT INFORMATION AND MEDICAL HISTORY
SOUTHERN TIER CANCER CARE

328 Delaware Ave, Olean, NY 14760
(716) 372 1046

Thank you for taking the time to complete this Patient Information and Medical History form. While it may appear lengthy, this information is very important for your care.

PATIENT'S NAME: ____
First Middle Last

DATE OF INITIAL VISIT: ____________________ SOCIAL SECURITY #: ____________________

PATIENT'S BIRTH DATE: ______________________ AGE: _______ MALE _____ FEMALE _____

PATIENT'S
ADDRESS: ____
No. Street Apt.#

____
City State Zip code

TELEPHONE: HOME: ( ) __________________ CELL: ( ) ______________________

WORK: ( ) ______________________ ALTERNATE: ( ) ______________________

OCCUPATION: _____________________ EMPLOYER: ____________________________________

HOW WOULD YOU LIKE THE STAFF TO ADDRESS YOU? ________________________________

PATIENT'S MARITAL STATUS: S M D W SPOUSE'S NAME: ___________________

EMERGENCY CONTACT (NOT SPOUSE): _____________________ RELATIONSHIP: __________

TELEPHONE: HOME: ( ) ________________ WORK: ( ) _________________________

PATIENT'S FAMILY DOCTOR: _________________ REFERRED BY DR: _____________________

PERSONAL HISTORY OF ILLNESS
Please answer all questions.

1. REASON FOR VISIT: ____

2. CURRENT SYMPTOMS: ____

____

____

Patient's Name: ________________________________

3. REVIEW OF SYMPTOMS: Have you recently experienced or are CURRENTLY EXPERIENCING?

CONSTITUTIONAL:
Fevers: Yes / No
Night Sweats: Yes / No
Fatigue: Yes / No
Have You Lost Any **Weight** Yes / No
If Yes→ How Much Over the Last 6 Months: __________
Are You Still Losing Weight Yes / No
Was Weight Loss Intentional? . Yes / No

EYES:
Glasses: Yes / No
Blurring Yes / No
Double Vision Yes / No

EAR, NOSE, THROAT:
Hard of Hearing Yes / No
Nosebleeds Yes / No
Sinus Drainage Yes / No
Sore Throat Yes / No
Hoarseness Yes / No

Do You Wear Dentures:
. Yes / No

SKIN/ BREAST:
Rash Yes / No
Itching Yes / No
Lump Yes / No
Discharge Yes / No

HEME/ LYMPH:
Bleeding Yes / No
Bruising Yes / No
Blood Clots Yes / No
Lumps Yes / No
Frequent Infections Yes / No

GASTROINTESTINAL:
Nausea/Vomiting Yes / No
Heartburn Yes / No
Constipation Yes / No
Feeling Full Yes / No
Bloating Yes / No
Diarrhea Yes / No
Blood in Stool Yes / No
Change in Stool Color Yes / No

GENITOURINARY:
Burning Yes / No
Frequency Yes / No
Dribbling Yes / No
Incontinence Yes / No
Blood in Urine Yes / No

CARDIOVASCULAR:
Chest Pain Yes / No
Shortness of Breath Yes / No
Edema Yes / No
Lightheadedness Yes / No

RESPIRATORY:
Cough Yes / No
Shortness of Breath Yes / No
Cough Up Blood Yes / No
Wheezing Yes / No

NEUROLOGICAL:
Tingling Yes / No
Numbness Yes / No
Focal/Localized Weakness Yes / No
Incoordination Yes / No
Dizziness Yes / No

PSYCHOLOGICAL:
Anxiety Yes / No
Depression Yes / No

MUSCULOSKELETAL:
Aches Yes / No
Pains Yes / No
Injuries Yes / No
Arthritis Yes / No
Difficulty Walking Yes / No
Difficulty Lifting Yes / No

_Do you have any **PAIN** Yes / No
If yes, describe where, when, severity and nature of pain
____

_Circle your **level of activity**
0: Asymptomatic; normal activity
1: Symptomatic; and fully ambulatory; able to carry out activities of daily living
2: Symptomatic; and in bed less than 50% of the day
3: Symptomatic; and in bed more than bed 50% of the day
4: Bedridden, may need hospitalization

4. PAST MEDICAL & SURGICAL HISTORY: Please underline/list and give details:

___**Any medical problems**, including problems with heart, high blood pressure, diabetes mellitus, peptic ulcer disease, stroke, lung, kidney, liver, cholesterol, osteoporosis, mental health, thyroid______________
____
____
____

___Any operations with **dates and reason for surgery**_____________________________________
____
____

___Any history of blood clots, bleeding, blood transfusions ______________________________

Patient's Name: __________________________________

5. PRESENT MEDICATIONS: (Include prescription and over-the-counter medications)

Name	Strength	Frequency	Reason	Approx. Start Date

6. Have you ever had any chemotherapy or radiotherapy? Yes / No

If yes, please give details

____

____

7. ALLERGIES:

Are you allergic to any medications? Yes / No

If yes, please list medication and **describe the reaction**.

____

____

8. SOCIAL HISTORY:

- Who is your closest relative/power of attorney_______________________________________
  Please give contact information and exact relationship: _________________________________
- Number and ages of children ____
- **Work History** (If retired, please describe previous occupation):____________________________
  ____
  ____
- **Tobacco Use**: Did you ever smoke? Yes / No   If yes, how many **maximum packs** per day ______
- What year did you begin to smoke _________   Have you quit? Yes / No
- If yes, when? (month / year) __________________   If no, do you understand the importance of quitting Yes / No
- Have you ever used any **chewing tobacco or illicit drugs**? Yes / No
  If yes, please give details ____
- **Do you** drink **alcohol** regularly   Yes / No
  If yes, Kind of drink: ___________# per day: __________# per week: ___________
- **Did you** ever drink **alcohol** regularly   Yes / No
  If yes, Kind of drink: ___________# per day: __________# per week: ___________

9: FAMILY HISTORY:
Has any blood relative ever had **cancer / blood disorders**? Yes / No
If yes, please describe **exact relationship**, **age of diagnosis** and **kind of cancer**: ___________________
____
____
____

	AGE & STATUS OF HEALTH	IF DECEASED, AGE AT AND CAUSE OF DEATH
Father		
Mother		
# of Brothers and Sisters		

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10. Do you have a **Health Care Proxy** / **Living Will / Advance Directive**: Yes/No **If yes, please bring in a copy**.

Do you wish to be **Resuscitated**: No / Yes / Don't know **If no, please bring in a copy of DNR Order Form**.

11: FOR WOMEN ONLY
Number of pregnancies? __________ Number of live births?______________ Miscarriages? ___________
Date of last menstrual period (Month/Year) ___________ Age at onset of menses (periods) ____________
Regular cycle/ Yes ______ No ______ Days of flow_______ Pain or cramps? Yes_______ No___________

Have you ever used **hormones supplements (Estrogen/Premarin, etc**.)?__________ Dates of Usage______
Have you ever used **oral contraceptives/birth control pills**? _________ Dates of Usage________________

When was your **last Pap Smear**? (Month/Year) ___________________________
When was your **last Mammogram?** (Month/Year) _________________________

OTHER THINGS YOU FEEL THE DOCTOR SHOULD KNOW ABOUT YOU OR YOUR FAMILY:
(Example: Adoption, diet, driving ability, transportation issues, living arrangements, ability to read, etc.)
____

____