HISTORY OF PRESENT ILLNESS

PHYSICIAN COMMENTS

Why did your doctor send you to CBCC for this consultation - chief complaint?

_____
_____
_____
_____

Did you discover the medical problem? Yes No

Did your doctor find it? Yes No

Have you been treated for this problem? Yes No
If yes, please give the date and location of the treatment/surgery:

Surgery:

Radiation:

Drug or other therapy (Chemotherapy):

Briefly describe your current medical problem. List symptoms and how long you have had them:

_____
_____
_____
_____

Do you have other medical problems that are now being treated? Yes No
If yes, please list them here:

_____ _____
_____ _____
_____ _____
_____ _____

PAST MEDICAL HISTORY

Please circle the illnesses that you have had. Provide the year for those needing hospitalization:

____Heart Disease	____Scarlet Fever	____Recurrent Pneumonia
____Cancer	____Hepatitis	____Kidney Disease
____Diabetes	____Stomach Ulcer	____Recurrent Bronchitis
____Emphysema	____Peptic Ulcer	____Venereal Diseases
____Hives	____Liver Disease	____Nervous Breakdown
____Asthma	____Jaundice	____Bleeding Disorder
____Tuberculosis	____Measles	____Rheumatic Fever
____Valley Fever	____Mumps	____High Blood Pressure
____Blood Clots	____Chicken Pox	____Shingles/Herpes Zoster
____Seizures	____ Anemia	____Any other serious illness

PHYSICIAN COMMENTS

Have you had any of the surgeries listed below? Please circle and give the year:

Appendix	_____	Artery	_____	Heart Problems	_____
Breast	_____	Colon	_____	Heart Surgery	_____
Eyes	_____	Gallbladder	_____	Hernia Repair	_____
Hip	_____	Knee	_____	Prostate Gland	_____
Lung	_____	Mastoids	_____	Thyroid Gland	_____
Ovary	_____	Nose	_____	Hemorrhoids	_____
Kidney	_____	Tubes Tied	_____	Tonsil & Adenoids	_____
Veins	_____	Uterus	_____	Dilatation & Curettage	____
Bone Marrow	_____	Bladder	_____		
Stomach	_____	Any Other	_____		

Have you ever had problems with anesthesia? Yes No
If yes, please state type of problem:

Have you ever had a blood transfusion? Yes No
If yes, Month _____ Year _____

Have you ever had a radiation treatment? Yes No
If yes, what part(s) of the body?

Have you had serious accidents or injuries? Yes No
If yes, please describe the accident or injury:

Please list the names of any Medications that you take regularly:

NAME	**DOSE**	**INSTRUCTIONS**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Would you like to have some of your prescriptions filled at our office?
Yes No

Are you **ALLERGIC** to any medications? Yes No Unknown
If yes, please name the medications and type of **ALLERGY**:

_____

_____

_____

_____

_____

PERSONAL HABITS (FOR EVERYONE)

PHYSICIAN COMMENTS

Please list the jobs that you have held: _____
_____
_____

Have you ever been exposed to any of the following?

Radiation	Yes	No	Insecticides	Yes	No
Petroleum Products	Yes	No	Benzene	Yes	No
Industrial Toxins	Yes	No			

Have you used tobacco? Yes No
If yes, list amount and type: _____
_____

Do you drink alcohol? Yes No
If yes, list amount and type: _____
_____

Have you been on a diet in the past? Yes No
If yes, list type of diet and the reason: _____
_____

Have you ever used "street drugs" (cocaine, marijuana, LSD, etc.)?
Yes No

RELIGIOUS BELIEFS (OPTIONAL)

Do you have a religious background? Yes No
If yes, please explain:
_____
_____

Do you think your religious beliefs have or will play any important role in your illness and treatment? Yes No

Would you like a doctor, nurse, or other staff member to pray with you?
Yes No

CANCER SCREENING

Have you had any of the following screening tests? If yes, when and where?

Type of Test	Yes	No	When	Where
Mammogram	___	___	_____	_____
Pap Smear	___	___	_____	_____
Prostate Exam	___	___	_____	_____
PSA	___	___	_____	_____
Colon Exam	___	___	_____	_____
Skin Exam	___	___	_____	_____
Chest x-ray	___	___	_____	_____

Has any member of your family had cancer? Yes ____ No ____

If yes, please see next page and list others here: _____
_____

FAMILY HISTORY FOR CANCERS

Place a check mark (√) in the boxes below for yourself and each family member who has had a cancer diagnosis as indicated.

Immediate Family Members	Breast Cancer Before Age 50	Breast Cancer After Age 50	Colon Cancer Before Age 50	Colon Cancer After Age 50	Endometrial Cancer Before Age 50	Endometrial Cancer After Age 50	Ovarian Cancer at Any Age	Other Cancers at Any Age List Type
Yourself								
Mother								
Father								
Sister(s)								
Brothers(s)								
Daughter(s)								
Son(s)								
MOTHER'S SIDE								
Grandmother								
Grandfather								
Aunt(s)								
Uncle(s)								
Cousin(s)								
FATHER'S SIDE								
Grandmother								
Grandfather								
Aunt(s)								
Uncle(s)								
Cousin(s)								

Any males with breast cancer at any age.

FAMILY HISTORY – GENERAL

PHYSICIAN COMMENTS

Please list the members of your immediate family, their ages, current health status, and if deceased, their cause of death.

Immediate Family Member	Age	Health Status			Cause of Death And Age
		Good	Fair	Poor	
Mother					
Father					
Sister(s)					
Brother(s)					
Daughter(s)					
Son(s)					

Has any family member had a blood disease? Yes No
If yes, please list relationship and type of blood disease.

Do any of the following conditions run in your family?

Twins	Yes	No
Birth defects	Yes	No
Tumors	Yes	No

Are you a twin? Yes No

Were you born with a birth defect? Yes No Please explain:

Additional comments:

REVIEW OF SYSTEMS

PHYSICIAN COMMENTS

Do you have, or have you had in the past 6 months, any of the following. Please **circle**.

General weakness	Fever of unknown cause	Night sweats
Skin rashes	Weight loss without cause	Chills
Change in taste	Enlarging moles	Loss of appetite
Sores not healing		

Do you have frequent/recurrent headaches?	Yes	No
Do you have frequent dizzy spells?	Yes	No
Have you ever fainted?	Yes	No
Have you had a recent change in eyesight?	Yes	No
Have you had recent change in hearing?	Yes	No
Do you have ringing or roaring in your ears?	Yes	No
Do you wear dentures?	Yes	No
Do they fit properly?	Yes	No
Do you have frequent sore throats?	Yes	No
Do you have trouble swallowing?	Yes	No
Do you have hoarseness without colds?	Yes	No
Have you lumps or swelling in the neck?	Yes	No
Do you cough up a lot of phlegm?	Yes	No
Have you coughed up blood?	Yes	No
Do you have coughing spells?	Yes	No
Do you get short of breath without exercise?	Yes	No
With exercise?	Yes	No
Have you had pains in your chest?	Yes	No
Have you been treated for heart problems?	Yes	No
Have you had high blood pressure?	Yes	No
Have you had thumping or racing heart?	Yes	No
Do your ankles swell?	Yes	No
Do you have frequent indigestion?	Yes	No
Do you have pain in your stomach?	Yes	No
Have you had frequent nausea or vomiting?	Yes	No
Have you ever vomited blood?	Yes	No
Have you had black bowel movements?	Yes	No
Have your bowel movements changed in the last 6 months?	Yes	No
Have you had blood in your bowel movements?	Yes	No
Do you notice burning on urination?	Yes	No
Do you get up every night to urinate?	Yes	No
Have you passed blood in your urine?	Yes	No
Have you passed a kidney stone?	Yes	No
Have you had root beer colored urine?	Yes	No
Any change in your desire for sexual activity?	Yes	No

PHYSICIAN COMMENTS

Have you noticed any change in your ability to engage in sexual activity?	Yes	No
Do you have joint trouble?	Yes	No
Do you have constant back pain?	Yes	No
Do you have constant bone pain?	Yes	No
Do you bruise easily?	Yes	No
Do you bleed easily?	Yes	No
Do your gums bleed frequently?	Yes	No
Do you have prolonged bleeding with cuts?	Yes	No
Do you have frequent nosebleeds?	Yes	No
Do you have feelings of sadness, depression, or anxiety?	Yes	No

FOR MEN ONLY

Do you have trouble urinating?	Yes	No
Have you been told you have prostate problems?	Yes	No
Have you been circumcised?	Yes	No

FOR WOMEN ONLY

How old were you when you began menstruating? _____
How old were you when you first became pregnant? _____
Do you still have periods? Yes No
If yes, please indicate date of last period: _____
If no, please list reason: Natural Surgery
Have you ever taken birth control pills? Yes No
Have you ever taken hormones? Yes No
When was your last pap smear? _____
Do you bleed between your periods? Yes No
Last mammogram: Date _____ Where? _____
Breast self exam? Yes No
Nipple discharge? Yes No
Palpable lumps? Yes No
Change in size or shape of nipples/breast? Yes No

Please indicate the following:

Number of pregnancies	_____	Number of cesareans	_____
Number of miscarriages	_____	Number of stillborn	_____
Number of premature births	_____	Number of abortions	_____
Number of children born alive	_____		

Have you had any complications of pregnancy? Yes No

_____

_____