Lancaster Cancer Center

Care Beyond Treatment

Patient Medical History

Name: ______________________________ **DOB:** ________________

Marital Status:

Single Married Divorced Widowed Significant Other

Living Arrangements:

Alone W/ Spouse With Child(ren)

With Spouse & Child(ren) Nursing Home Other

Occupation:

Current or Most Recent __________________________________

Occupational Exposure __________________________________

Smoking:

Never a smoker _____

Current smoker _____ Packs per day _____ Year History _____

Former smoker _____ Packs per day _____ Year History_____ Year Quit _____

Alcohol:

Never _____ Current use _____ Former use _____ Socially _____

Drinks per day _____ Drinks per week_____ Drinks per month _____

Illicit Drug Use:

Never _____

Current _____ Substance used ____________________

Former _____ Substance used ____________________

Living Will: YES NO

Do Not Resuscitate: YES NO

Power of Attorney: YES NO **Name of POA**: ______________________

Allergy List

Drug Allergy	Reactions

Name: ____________________________ **DOB:** ________________

Medication List

Drug	Dose	Instructions

<u>Current Medical Conditions</u> (please circle)

Abnormal chest x-ray
Abnormal EKG
Alzheimer's
Anemia
Anxiety
Arthritis
Asthma
Bleeding Disorder
Blindness
History of Caner
Cataracts
Depression
Diabetes
Diverticulitis

Fibroids
Fibromyalgia
Goiter
Gout
Heart Burn
Heart Disease
Heart Murmur
Hernia
Hepatitis
Hypertension
Hypercholesteremia
Low Blood Sugar
Impotence
Irritable Bowel

Kidney Disease
Liver Disease
Lung Disease
Melanoma
Migraines
Osteoporosis
Panic Attacks
Phlebitis
Polio
Enlarged Prostate
Raynaud's
Seizures
Stroke
Thyroid Disorder

Name: ___________________________ **DOB: _______________**

Past Surgical History

Procedure	Date

Health Screening

		Date Last Received
Breast Exam	Y / N	
Mammogram	Y / N	
Pap Smear	Y / N	
Colonoscopy	Y / N	
Dexa Scan	Y / N	
Flu Vaccine	Y / N	
Pneumovax	Y / N	

Have you ever received a blood transfusion? yes / no

OB/GYN History

Menstruation	Age at first period:	Age at Menopause:	
Birth History	# of pregnancies:	# of live births:	Age at First Birth:
Contraception:	Current Use: Yes / No Former Use: Yes / No	Type Used:	Year Discontinued:
Hormonal Therapy	Current Use: Yes / No Former Use: Yes / No	Estrogen: Yes / No Progesterone: Yes / No	Year Discontinued:

Name: ____________________________ **DOB:** ________________

Family History

	Living	Age / Age at Death	List All Health Conditions	If Deceased, List Cause of Death
Mother	Y / N			
Father	Y / N			
Sister (s)	Y / N			
	Y / N			
	Y /N			
Brother (s)	Y / N			
	Y / N			
	Y / N			
Children	Y / N			
	Y / N			
	Y / N			

Family Cancer History (please be specific as you can to assist with genetic counseling)

	You / Age	Children / Age	Mother's Side /Age	Father's Side/ Age
Breast				
Metastatic Breast				
Ovarian				
Prostate				
Male Breast				
Pancreatic				
Melanoma				
Colon				
Uterine				

Are you of Ashkenazi Jewish Decent? YES / NO

Name: ____________________________ **DOB: ________________**

Symptom			Symptom		
Weight Loss	YES	NO	Vaginal Bleeding	YES	NO
Fatigue	YES	NO	Burning with Urination	YES	NO
Loss of Appetite	YES	NO	Pain with Urination	YES	NO
Night Sweats	YES	NO	Blood in Urine	YES	NO
Fever	YES	NO	Frequent Urination	YES	NO
			Incontinent of Urine	YES	NO
Blurry Vision	YES	NO			
Double Vision	YES	NO	Muscle Pain	YES	NO
Hearing Loss	YES	NO	Joint Pain	YES	NO
Ringing in Ears	YES	NO	Joint Swelling	YES	NO
Sinus Congestion	YES	NO	Back Pain	YES	NO
Difficulty Swallowing	YES	NO	Stiffness	YES	NO
Sore Throat	YES	NO	Ambulates with Cane / Walker	YES	NO
Nasal Drainage	YES	NO			
Frequent Nose Bleeds	YES	NO	Skin Rash	YES	NO
			Skin Lesion / Wound	YES	NO
Chest Pain	YES	NO			
Heart Palpitations	YES	NO	Headache	YES	NO
Swelling in Legs	YES	NO	Seizures	YES	NO
Dizziness	YES	NO	Loss of Balance	YES	NO
			Weakness of Limbs	YES	NO
Dry Cough	YES	NO	Neuropathy	YES	NO
Productive Cough	YES	NO	Memory Loss	YES	NO
Blood in Sputum	YES	NO	Confusion	YES	NO
Shortness of Breath- Exertion	YES	NO			
Shortness of Breath- Lying down	YES	NO	Depression	YES	NO
			Anxiety	YES	NO
Nausea / Vomiting	YES	NO	Difficulty Sleeping	YES	NO
Heart Burn	YES	NO			
Constipation	YES	NO	Easy Bruising	YES	NO
Diarrhea	YES	NO	Easy Bleeding	YES	NO
Abdominal Pain	YES	NO	Swollen Node in Armpit	YES	NO
Rectal Bleeding	YES	NO	Swollen Node in Groin	YES	NO
Rectal Stool Incontinence	YES	NO	Swollen Node in Neck	YES	NO