Lancaster Cancer Center
Care Beyond Treatment

Print Form

Patient Name: _____ **Date:** _____

Social History / Occupational History

		Type & Amount	How many years?
Do you use tobacco now?	☐ Yes ☐ No		
Have you used tobacco in the past?	☐ Yes ☐ No		
Do you use alcohol now?	☐ Yes ☐ No		
Have you used alcohol in the past year?	☐ Yes ☐ No		
Do you use recreational drugs now?	☐ Yes ☐ No		
Have you used recreational drugs in the past?	☐ Yes ☐ No		

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Seperated

Do you live: ☐ alone ☐ with spouse ☐ with children ☐ other

Are you presently employed? ☐ Yes ☐ No

Most recent occupation: _____

Previous occupation(s): _____

Do you have a Living Will? ☐ Yes ☐ No

OB / Gyn

Age of first menstrual period: _____

Are you periods regular? ☐ Yes ☐ No

Date of last menstrual period: _____

Number of pregnancies: _____

Number of live births: _____

Menopause: ☐ Yes ☐ No

Onset date: _____

Have you ever taken birth control pills? ☐ Yes ☐ No

Have you ever taken hormone replacement therapy? ☐ Yes ☐ No

Screening History

Date of your last:

Pap smear _____

Breast exam _____

Flu shot _____

Pneumonia shot _____

Mammogram _____

Colonoscopy _____

Dexa scan _____

Reviewed by: _____ Date: _____

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Past Medical History: Please check if you have had any problems with any of the following:

- ☐ Abnormal Chest X-Ray
- ☐ Abnormal EKG
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blindness
- ☐ Blood clot
- ☐ Breast disease
- ☐ Cancer
  - Type: _____
- ☐ Carpal tunnel syndrome
- ☐ Cataracts
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Ear Infections
- ☐ Fibroids
- ☐ Gall bladder disease
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Hay fever
- ☐ Heartburn
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypoglycemia
- ☐ Impotence
- ☐ Irritable bowel syndrome
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Melanoma
- ☐ Migraine/headaches
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Panic Attacks
- ☐ Phlebitis
- ☐ Polio
- ☐ Prostate enlargement
- ☐ Raynauds
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Skin cancer
- ☐ Stroke
- ☐ Syphyllis
- ☐ Thyroid problem
- ☐ Tuberculosis

Past Surgical History: Please list your past surgeries and dates:

Family History:

	Living	Age or age at death	List serious illnesses	If deceased: list cause of death
Mother	☐ Yes ☐ No			
Father	☐ Yes ☐ No			
Sisters	☐ Yes ☐ No			
Brothers	☐ Yes ☐ No			
Children	☐ Yes ☐ No			

Reviewed by: _____ Date: _____