ALABAMA ONCOLOGY®

# Patient History

Name: ______________________________ Date: ______________

Referring Physician: ______________ Primary Care Physician: ______________

Other Physicians: ______________________________

**Do you have an Advance Directive?** ❑ Yes ❑ No

**Do you have any of the following:**

❑ Heart Attack
❑ Heart Failure
❑ Mitral Vale Prolapse
❑ Irregular Heart Beat
❑ Kidney Disease
❑ Dialysis
❑ Kidney Stones
❑ Glaucoma
❑ Arthritis
❑ Cataracts
❑ Asthma
❑ Bronchitis
❑ Emphysema
❑ Stomach Ulcers
❑ Hiatal Hernia
❑ Stroke
❑ Diabetes
❑ High Blood Pressure
❑ Gallbladder
❑ Cancer
Type: ______________

Do you have any other health problems not mentioned above? ______________________________

**Have you had:**

Previous Radiation Therapy (if yes, give year/location) ______________________________

Previous Chemotherapy (if yes, give year/location) ______________________________

**Please list any previous surgeries and the approximate year of each surgery:**

______________________________

______________________________

**Have you ever been exposed to any carcinogens? (asbestos, silica, radiation)** ❑ Yes ❑ No

If yes, please list: ______________________________

**Have you ever had a blood transfusion:** ❑ Yes year______________ ❑ No

**Has anyone in your blood-related family had or currently have any of the following problems, if yes please identify relationship:**

❑ Cancer - Type: ______________

Relationship: ______________

❑ Diabetes - Relationship: ______________

❑ Heart Disease - Relationship: ______________

**Are you:** ❑ non-smoker
❑ smoker - packs per day ______________
❑ ex-smoker - packs per day/year quit ______________

**Do you drink alcohol?** ❑ Yes ❑ No If yes, how many drinks per week? ______________