ALABAMA ONCOLOGY®

ANNUAL PATIENT HISTORY

Name:_____ Age:_____ Date:_____

Do you currently have any chronic medical conditions? If yes, describe:

Diabetes ❑ Yes ❑ No
Heart Disease ❑ Yes ❑ No
Stroke ❑ Yes ❑ No
High Blood Pressure ❑ Yes ❑ No
Chronic Lung Disease ❑ Yes ❑ No
Cancer Type?_____ ❑ Yes ❑ No

Please Describe:_____

RECENT HOSPITAL / ER VISIT:

Year Hospital Reason

1. _____
2. _____
3. _____

Have you had a blood transfusion? ❑ Yes ❑ No

HISTORY OF:

Cancer ❑ Yes ❑ No Type?_____ Date_____
Radiation ❑ Yes ❑ No Date_____
Chemotherapy ❑ Yes ❑ No Date_____
Surgeries _____
_____

ADVANCED CARE DIRECTIVES:

Do you have a living will? ❑ Yes ❑ No Do you have a Healthcare/Medical Power of Attorney? ❑ Yes ❑ No
Do you have a DNR (Do Not Resuscitate)? ❑ Yes ❑ No
If you answered "Yes" to any of the above questions, please provide our office with a copy for your records.

IMMUNIZATIONS:

Influenza Vaccine ❑ Yes ❑ No Date_____
Tetanus Vaccine ❑ Yes ❑ No Date_____
Shingles Vaccine ❑ Yes ❑ No Date_____
Pneumonia Vaccine ❑ Yes ❑ No Date_____
Hepatitis Vaccine ❑ Yes ❑ No Date_____
COVID/Booster Vaccine ❑ Yes ❑ No Date_____

FAMILY HISTORY: ❑ TB ❑ Heart Disease ❑ Blood Disease Type?_____

FAMILY CANCER HISTORY:

FAMILY MEMBER	LIVING STATUS	CANCER TYPE	AGE	FAMILY MEMBER	LIVING STATUS	CANCER TYPE	AGE
Mother	❑ Living ❑ Deceased			Grandparent	❑ Living ❑ Deceased		
Father	❑ Living ❑ Deceased			Sibling	❑ Living ❑ Deceased		
Children	❑ Living ❑ Deceased			Aunts / Uncles	❑ Living ❑ Deceased		

Do you use any of the following?:

Alcohol: ❑ Yes ❑ No Type:_____ How much?_____ How often?_____ If quit, when?_____
Tobacco: ❑ Yes ❑ No Type:_____ How much?_____ How often?_____ If quit, when?_____
Vape: ❑ Yes ❑ No Type:_____ How much?_____ How often?_____ If quit, when?_____
Recreational Drugs: ❑ Yes ❑ No Type:_____ How much?_____ How often?_____ If quit, when?_____
Sunscreen: ❑ Yes ❑ No
Other exposures: Toxins (i.e. Asbestos, Silica or Radiation) Work or Home? ❑ Yes ❑ No
If so, please describe:_____

Reproductive History:

Female: Number of pregnancies: _____ Number of children: _____ Age at first pregnancy: _____
Did you breastfeed: ❑ Yes ❑ No If yes, how many months (approximate): _____
Age at first period:_____ Age at menopause:_____ Age at last period:_____ Hot Flashes ❑ Yes ❑ No
Hysterectomy: ❑ Yes ❑ No Ovaries intact: ❑ Yes ❑ No If no, please explain: _____
Hormone use: ❑ Yes ❑ No Contraception: ❑ None ❑ Birth control ❑ Other_____

Male: Impotence (Erectile Dysfunction): ❑ Yes ❑ No Number of children:_____ Vasectomy: ❑ Yes ❑ No

Name:_____ Age:_____ Date:_____

Have you ever had a colonoscopy? ❑ Yes ❑ No Date_____ Ordering Physician/Location _____	Office Use: 73761001
Have you ever had a mammogram? ❑ Yes ❑ No Date_____ Ordering Physician/Location _____	Office Use: 24623002

PAIN ASSESSMENT: Do you have pain? ❑ Yes ❑ No If yes, location:_____

Severity of Pain 0-10 (0=no pain; 10=extreme pain)_____ Description: ❑ Burning ❑ Sharp ❑ Dull ❑ Other_____

What Treatment/Medications do you use for pain:_____ Is the pain controlled with medication? ❑ Yes ❑ No

Is your pain ❑ Acute (New Onset) or ❑ Chronic (Long Term) Who manages your pain?_____

EMOTIONAL WELL-BEING: In the past two weeks have you experienced:

Problems with Sleeping? ❑ Yes ❑ No Loss of interest/pleasure in doing things? ❑ Yes ❑ No

Depression or feeling down? ❑ Yes ❑ No Anxiety? ❑ Yes ❑ No

List any medications you take for Anxiety/Depression:_____ Are your symptoms controlled? ❑ Yes ❑ No

IN THE LAST YEAR, HAVE YOU HAD?

Skin:	**Yes**	**No**		**GI:** (Date of Last Endoscopy:_____)	**Yes**	**No**
Itching Rash/Ulcers				Nausea/Vomiting		
				Diarrhea		
General:				Constipation		
Fatigue (if yes, rate 0-10)_____				Indigestion		
Fever/Chills				Abdominal Pain		
Night Sweats				Painful Swallowing		
Weight Loss				Loss of Appetite		
				Blood in Stool		
Ears, Eyes, Nose, Throat:				Stomach Ulcers		
Hearing Loss						
Ringing in Ears				**Urinary:** (Male - Last PSA level:_____)		
Vision Changes				Urinating at Night		
Nose Bleeds				Difficulty Urinating		
Problems with Teeth or Gums				Pelvic Pain		
Glaucoma				Loss of Sexual Interest		
Cataracts				Blood in Urine		
Hoarseness				Kidney Disease		
				Dialysis		
Heart and Blood Vessels:						
Chest Pain/Palpitations				**Skeletal:**		
Shortness of Breath on Effort				Pain in Joints		
Irregular Heart Beat				Back Pain		
Fainting or Dizziness				Muscle Weakness		
				Arthritis		
Lungs: (Date of last chest x-ray:_____)						
Chest pain with Breathing				**Neurological:**		
Asthma Attacks				Pain/Numbness in Hands/Feet		
Cough				Vertigo/Difficulty with Balance		
Bloody Sputum				Weakness on One Side		
COPD				Frequent Headaches		
Emphysema						