INSPIRE ONCOLOGY

Patient Self-History Form

Patient name: _____DOB: _____Age: ____Male_____ Female_____

Marital Status: Single ____ Married ____Partnered ____ Separated ____Divorced ____Widowed ____

ALLERGIES:

Are you allergic to IV contrast: Y_____N_____ If yes, reaction _____

Are you allergic to latex: Y_____N_____ If yes, reaction: _____

Are you allergic to any medications: Y_____N_____

Other Allergies: (drug, food, tape, etc.) _____

Pharmacy Name: _____Pharmacy Number _____

MEDICATIONS LIST:

Medications	Dose	Frequency	Prescribing Physician

Patient Self-History Form

HAVE YOU HAD THE FOLLOWING? (check all that apply)

Cancer diagnosis type: _____

Prior Cancer_____ Site_____	Prior Radiation_____ When_____	Prior Chemotherapy_____ When_____

Lupus_____
Scleroderma_____
Blood Disorders_____
Anemia_____
Blood Clots_____
Heart Disease_____
Heart Attack_____
Defibrillator/Pacemaker_____
Hypercholesterolemia_____
Hypertension_____
Gastroesophageal Reflux_____
Nausea/Vomiting_____
Loss of Appetite_____
Hiatal Hernia_____
Colon Polyps_____
Blood in stool_____
Dark/Black stool_____
Diverticulitis_____
Diverticulosis_____

Inflammatory Bowel disease_____
Diarrhea_____
Constipation_____
Hemorrhoids_____
Headaches_____
Vertigo_____
Seizure_____
Stroke_____
Paralysis_____
Fatigue_____
Weakness_____
Polio_____
Tremors_____
Anxiety_____
Depression_____
Bipolar Disorder_____
Psychosis_____
Glaucoma_____
Cataracts____

Night Blindness_____
Glasses/Contacts_____
Hearing Loss_____
Hearing Aid_____
Asthma_____
Hoarseness_____
Dysphagia_____
Cough_____
Emphysema_____
COPD_____
Pneumonia_____
Chronic Bronchitis_____
Positive TB test_____
Hematuria_____
Pain with Urination_____
Urinary Incontinence_____
Frequent Urination_____
Uterine Fibroids_____

Patient Name_____ DOB_____

Patient Self-History Form

SURGICAL HISTORY

Amputation _____

Appendectomy _____

Biopsy _____

Bone Marrow Transplant _____

Cataracts _____

Cholecystectomy (gallbladder) _____

Colon or Rectal Surgery _____

Colposcopy_____

Cystectomy _____

Colonoscopy_____

Heart by-pass _____

Heart Stent _____

Heart Valve Replacement _____

Lobectomy _____

Hernia Repair _____

Hysterectomy _____

D & C _____

Tubal Ligation _____

Lumpectomy _____

Mastectomy _____

Breast Implants _____

Melanoma _____

Ovarian _____

Prostatectomy _____

Thyroidectomy _____

Vasectomy _____

Joint Replacement _____

Other _____

CURRENT HEALTH

Current Height: _____

Current Weight: _____

Recent Weight loss/gain: Y_____N_____

If yes, how much: _____

Nutritional Status: Good_____ Fair____ Poor_____

Quality of Life: Good_____ Fair_____ Poor_____

Are you sexually active: Y_____N_____

Do you have dentures: Y_____N_____

Influenza Vaccination Y_____N_____

Date: _____

Patient Self-History Form

FEMALE: Please complete the following information

Date of last Pap Smear: _____ Results: Positive ____ Negative _____ Unknown _____

Date of last Mammogram: _____ Results: Positive ____ Negative _____ Unknown _____

Bra cup size: _____ Nipple Discharge : Y_____N_____

When did you start having menstrual periods? Age/Year of 1st period: _____

Are you currently having menstrual periods? Y_____N_____

Are you, or is there any chance, you might be pregnant? Y_____N_____

Number of Pregnancies: ____Number of Deliveries: ____ Your age when first child born: ____

Did you breast feed any of your children: Y_____N_____

Did you ever take hormones: (i.e. Estrogens, Birth Control Pills, Androgens)? Y_____N_____

If yes, Type: _____How many years? _____

FAMILY HISTORY:

Father: If living, age _____ If deceased, age at death ____

History of Cancer/Blood Disorder _____

Mother: If living, age ____ If deceased, age at death ____

History of Cancer/Blood Disorder _____

Is there any other family history of Blood Disorder or Cancer? Y_____N_____

If yes, please describe: _____

Patient Self-History Form

SOCIAL HISTORY:

Have you ever smoked? Y_____N_____ if yes, how long? _____ packs per day? _____

Cigarette's _____ Cigars _____

Have you quit smoking? Y_____N_____ if yes, when? _____

Have you attended tabaco cessation classes: Y_____N_____

Do you drink alcoholic beverages? Y_____N_____ If yes, how often? _____

SOCIAL GEOGRAPHIC HISTORY:

In which state (or country), were you born? _____

Are you a full time resident of Florida? Y_____N_____

If No, what other state do you live in? _____

OCCUPATION:

What is/was your primary occupation? _____

Are you still working? Y_____N_____

Have you served in the military? Y_____N_____

Did you ever work in an occupation that involved exposure to asbestos or any other cancerous chemicals, fumes, or carcinogens? Y_____N_____

If yes, describe: _____

Please list the names and addresses of physicians you would like correspondence sent to:

_____

_____

_____

_____