Women's Cancer Care Associates, LLC

Initial Patient History and Physical

Patient Name: _____Prefers to be Called:_____
Date of Birth: _____/_____/_____

OUTSIDE PHYSICIANS

Primary Doctor: _____ Phone: _____
OBGYN: _____ Phone: _____
Cardiologist: _____ Phone: _____
Other Doctors: _____ Phone: _____
_____ Phone: _____
_____ Phone: _____

PHARMACY

Local Pharmacy: _____ City: _____ Phone: _____
Mail Order Pharmacy (if used): _____ Phone: _____

SOCIAL HISTORY

MARITAL STATUS
☐ Single ☐ Married
☐ Separated ☐ Divorced ☐ Widowed
☐ Significant Other/Domestic Part.

LIVING ARRANGEMENTS
☐ Alone ☐ Spouse/Significant Other ☐ Children
☐ Facility/Supervised Living
☐ Other: _____

NEXT OF KIN
Name: _____Phone: _____Relationship: _____

EMPLOYMENT
Currently Employed: ☐ Yes ☐ No Employer: _____ Occupation: _____

TOBACCO USE
☐ I do not smoke
☐ I am an ex-smoker who quit on _____
☐ I currently smoke _____packs/day for _____ years

DRUG/ALCOHOL USE
☐ I do not drink alcohol ☐ I do not use street drugs
☐ I drink alcohol: how often _____ how much _____
☐ I used drugs: type:_____when_____
☐ I currently use drugs:type _____

FAMILY HISTORY

	Present Age	Age at Death	Present Health Condition or Cause of Death
Father			
Mother			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			

Do any other members of your family have a history of cancer (aunts, uncles, cousins, grandparents)? If yes, please explain:

_____
_____
_____

Women's Cancer Care Associates, LLC Initial Patient History and Physical

ADVANCE DIRECTIVES

I have a ☐ Living Will ☐ Healthcare Proxy ☐ Appointed Power of Attorney (Name:_____)
I would like more information on ☐ Living Will ☐ Healthcare Proxy

MEDICAL HISTORY

ALLERGIES

☐ I have no known allergies
☐ I am allergic to _____
What happens (rash,etc)?_____

CURRENT MEDICATIONS- list all medications you currently take including vitamins, supplements, and over the counter

Medication	Dose	Times Daily

DO YOU OR HAVE YOU EVER HAD?

☐ Heart Condition ☐ High Blood Pressure
☐ Stroke ☐ Diabetes
☐ Asthma ☐ Lung Problems/COPD
☐ Arthritis ☐ Seizure disorder
☐ Thyroid Issues ☐ Cancer _____
☐ Depression/Anxiety ☐ Skin Diseases/Psoriasis
☐ AIDS/HIV ☐ Anemia/Blood Disorder
☐ Colitis/Crohns ☐ Chicken Pox/Shingles
☐ Headaches ☐ Kidney disease
☐ Gallbladder Issues ☐ Jaundice
☐ Hepatitis

☐ Radiation – body part?_____when_____
☐ Chemotherapy- type _____when_____

☐ Flu Vaccine- when? _____
☐ Pneumonia Vaccine-when? _____
☐ Hepatitis Vaccine-when? _____
☐ Colonoscopy- when? _____
☐ Mammogram-when? _____

HAVE YOU EVER HAD SURGERY?	
Type	Month/Year

Do you have any other chronic medical conditions not listed above? _____
_____
_____

GYNECOLOGIC HISTORY

Menstrual/Gynecologic History

Age at First Menstrual Period _____ Date of Last Period _____ Age at Menopause _____
Do you now use birth control? ☐ No ☐ Yes- type? _____how long? _____
Have you ever taken hormone replacements? ☐ No ☐ Yes- how long? _____
Have you ever had? ☐ Herpes ☐ HPV/Genital warts ☐ Chlamydia ☐ Pelvic Inflammatory Disease
Are you currently sexually active? ☐ Yes ☐ No

Obstetrical History

Have you ever been pregnant? ☐ No ☐ Yes How many times? _____
Number of vaginal deliveries: _____ C-Section:_____ Termination: _____Miscarriage: _____

REVIEW OF SYSTEMS

Are you ***currently*** experiencing any of the following?:

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats

Eyes
- ☐ No problems or concerns
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Vision loss
- ☐ Other: _____

Ear, Nose, Mouth, Throat
- ☐ No problems or concerns
- ☐ Hearing loss
- ☐ Dental problems
- ☐ Other: _____

Cardiology
- ☐ No problems or concerns
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Pacemaker/defibrillator
- ☐ Irregular heartbeat
- ☐ Leg/ankle swelling
- ☐ Other: _____

Respiratory
- ☐ No problems or concerns
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Cough
- ☐ Other: _____

Gastrointestinal
- ☐ No problems or concerns
- ☐ Loss of appetite
- ☐ Heartburn or indigestion
- ☐ Abdominal pain or discomfort
- ☐ Recurrent diarrhea
- ☐ Recurrent constipation
- ☐ Bloody stool
- ☐ Other: _____

Genitourinary
- ☐ No problems or concerns
- ☐ Difficult or painful urination
- ☐ Frequent urination
- ☐ Recurrent bladder infection
- ☐ Vaginal itching
- ☐ Vaginal discharge
- ☐ Irregular periods
- ☐ Painful periods/cramping
- ☐ Heavy periods
- ☐ Sexual problems
- ☐ Lump or sore on vulva
- ☐ Other: _____

Musculoskeletal
- ☐ No problems or concerns
- ☐ Difficulty walking
- ☐ Joint aches or stiffness
- ☐ Backache/pain
- ☐ Other: _____

Breast
- ☐ No problems or concerns
- ☐ Lump in breast
- ☐ Pain in breast
- ☐ Change in breast size
- ☐ Other: _____

Skin
- ☐ No problems or concerns
- ☐ Sores
- ☐ Rashes
- ☐ Moles
- ☐ Other: _____

Neurologic
- ☐ No problems or concerns
- ☐ Difficulty concentrating
- ☐ Frequent headaches
- ☐ Dizziness/fainting
- ☐ Numbness in hands
- ☐ Numbness in feet
- ☐ Seizures/convulsions
- ☐ Other: _____

Psychosocial
- ☐ No problems or concerns
- ☐ Nightmares
- ☐ Anxious/nervous
- ☐ Trouble sleeping
- ☐ Lonely/depressed
- ☐ Work/family issues
- ☐ Other: _____

Hematologic/Lymphatic
- ☐ No problems or concerns
- ☐ Easy bleeding or bruising
- ☐ Anemia or other blood issues
- ☐ Frequent infections
- ☐ Swelling of glands
- ☐ Other: _____

PLEASE SIGN

I authorize Women's Cancer Care Associates, LLC to use and disclose my protected health information as reasonably necessary for treatment, payment, and health care operations.

X _____ _____

Patient's Signature Date