

SOLACE CANCER CARE  
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THANK YOU FOR CHOOSING OUR OFFICE. IN ORDER TO SERVE YOU PROPERLY WE WILL NEED THE FOLLOWING INFORMATION. ALL INFORMATION WILL BE STRICTLY CONFIDENTIAL.

### HISTORY AND PHYSICAL FORM

Name \_\_\_\_\_

Date \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Referring Physician \_\_\_\_\_ Family doctor \_\_\_\_\_

Place of employment \_\_\_\_\_

Occupation (if retired what was your usual occupation) \_\_\_\_\_

Why did you come to the office today? \_\_\_\_\_

\_\_\_\_\_

Was your breast problem, detected by \_\_\_\_\_ yourself \_\_\_\_\_ physician \_\_\_\_\_ mammogram?

How long have you known about it? \_\_\_\_\_

Has anything changed since you first noticed it? \_\_\_\_\_

Previous breast surgery? \_\_\_\_\_

Right \_\_\_\_\_ Left \_\_\_\_\_ Date \_\_\_\_\_ Place \_\_\_\_\_

Findings \_\_\_\_\_

Do you do monthly breast self-exam? \_\_\_\_\_

Date last menstrual period? \_\_\_\_\_

Age menarche (first menstrual period) \_\_\_\_\_

Age of first live birth \_\_\_\_\_ Number of pregnancies \_\_\_\_\_

Number of children \_\_\_\_\_ Number of miscarriages/abortions \_\_\_\_\_

Is there any chance that you could be pregnant now? \_\_\_\_\_

Age of menopause \_\_\_\_\_ Natural \_\_\_\_\_ or Surgical \_\_\_\_\_

Have you ever taken estrogen? \_\_\_\_\_ If so, how long? \_\_\_\_\_

Are you taking estrogen now? \_\_\_\_\_ Dosage? \_\_\_\_\_

Any family history of breast cancer? \_\_\_\_\_ If so, please give:

Relationship	Age of Diagnosis	Current state of health
_____	_____	_____
_____	_____	_____

Any family history of ovarian cancer? \_\_\_\_\_

Are you of Ashkenazi Jewish decent? \_\_\_\_\_

Family History:

	General Health	Medical Problems	If deceased, cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

Have you ever had any operations? \_\_\_\_\_ If yes, what kind of operations, when and where performed?

\_\_\_\_\_

\_\_\_\_\_

Any other hospitalization? (not including the operations listed above) \_\_\_\_\_ If yes, please list the reason, date and hospital \_\_\_\_\_

\_\_\_\_\_

Any active medical problems? \_\_\_\_\_

\_\_\_\_\_

Allergies & types of reactions \_\_\_\_\_

\_\_\_\_\_

Are you allergic to Latex? \_\_\_\_\_

Are you taking drugs, medications, laxatives, birth control pills, hormones, pain pills or herbal products?\_\_\_\_\_If yes, please list:

<u>Medication</u>	<u>Why</u>	<u>Dosage</u>	<u>How Often?</u>

Have you taken steroids in the past year?\_\_\_\_\_

Have you ever had or been exposed to hepatitis?\_\_\_\_When?\_\_\_\_\_What type?\_\_\_\_\_

Have you ever been exposed to HIV/AIDS? If yes, please explain\_\_\_\_\_

Have you or anyone in your family had any bleeding problems?\_\_\_\_\_

Problems with anesthesia?\_\_\_\_\_Problems with sickle cell syndroime/trait?\_\_\_\_\_

Tobacco: How much to you smoke per day?\_\_\_\_\_How long have you smoked?\_\_\_\_\_If you do not smoke now, have you ever smoked?\_\_\_\_\_If yes, how long and when did you quit?\_\_\_\_\_

Alcohol: Do you drink alcohol?\_\_\_\_\_If yes, what do you drink?\_\_\_\_\_How much?\_\_\_\_\_How often\_\_\_\_\_Have you ever had a problem with Alcohol?\_\_\_\_\_

Drugs: Do you take any recreational or illicit drugs?\_\_\_\_\_Have you ever been an IV drug user?\_\_\_\_\_

Please check the line if you have had any of the following:

- General:
  - Recent weight loss\_\_\_\_\_
  - Recent weight gain\_\_\_\_\_
  - High Blood Pressure\_\_\_\_\_
  - Fevers\_\_\_\_\_
  - Night Sweats\_\_\_\_\_
  - Fatigue\_\_\_\_\_
- Throat/Mouth:
  - Dentures\_\_\_\_\_
  - Missing /loose teeth\_\_\_\_\_
  - Tooth abscess\_\_\_\_\_
  - Cancer\_\_\_\_\_

Please check the line if you have had any of the following:

Eyes:

Visual aids \_\_\_\_\_  
Cataracts \_\_\_\_\_  
Glaucoma \_\_\_\_\_  
Double Vision \_\_\_\_\_

Musculoskeletal:

Blood clots in legs (phlebitis) \_\_\_\_\_  
Arthritis \_\_\_\_\_  
Pain in joints \_\_\_\_\_  
Difficulty walking \_\_\_\_\_  
Broken bones \_\_\_\_\_  
Major injury \_\_\_\_\_  
Weakness in arms/legs \_\_\_\_\_  
Osteoporosis \_\_\_\_\_

Neurological:

Strokes \_\_\_\_\_  
TIA's \_\_\_\_\_  
Epilepsy/seizures \_\_\_\_\_  
Memory loss/Alzheimer's' \_\_\_\_\_  
Numbness/tingling \_\_\_\_\_

Psychiatric:

History of depression \_\_\_\_\_  
History of psychiatric disorders \_\_\_\_\_

Hematologic:

Problems with platelets \_\_\_\_\_  
Leukemia \_\_\_\_\_  
Anemia \_\_\_\_\_  
Bleeding problems \_\_\_\_\_  
Problems with blood clots \_\_\_\_\_

Gyn:

History abnormal PAP \_\_\_\_\_  
Uterine cancer \_\_\_\_\_  
Cervical cancer \_\_\_\_\_  
Ovarian cancer \_\_\_\_\_  
Endometriosis \_\_\_\_\_  
Abnormal vaginal bleeding \_\_\_\_\_

Skin:

Chronic skin problems \_\_\_\_\_

Endocrine:

Diabetes \_\_\_\_\_  
Thyroid disease \_\_\_\_\_  
Adrenal disease \_\_\_\_\_  
Parathyroid disease (high calcium) \_\_\_\_\_

Please check the line if you have had any of the following:

Ears:

Hearing aids \_\_\_\_\_  
Chronic ear infections \_\_\_\_\_  
Deafness \_\_\_\_\_

Eyes:

Any changes in bowel movements \_\_\_\_\_  
Blood or blackness in your bowel movements \_\_\_\_\_  
Pancreatitis \_\_\_\_\_  
Ulcers \_\_\_\_\_  
Hernias \_\_\_\_\_  
Colon cancer \_\_\_\_\_  
Gallbladder disease \_\_\_\_\_  
Bowel obstruction \_\_\_\_\_  
Reflux(heartburn) \_\_\_\_\_  
Liver problems \_\_\_\_\_  
Hepatitis \_\_\_\_\_

GU:

Kidney problems \_\_\_\_\_  
Any blood , pain or burning w/urination \_\_\_\_\_  
Incontinence \_\_\_\_\_  
Cancer of bladder or kidneys \_\_\_\_\_

Cardiovascular:

Chest pain (angina) \_\_\_\_\_  
Heart attack \_\_\_\_\_  
Heart murmur \_\_\_\_\_  
Heart failure \_\_\_\_\_  
Heart surgery \_\_\_\_\_  
Palpitations, rapid irregular heart beats \_\_\_\_\_  
Coronary ateriogram (cardiac catherization) \_\_\_\_\_  
Take antibiotics prior to dental work \_\_\_\_\_

Pulmonary:

Asthma \_\_\_\_\_  
Wheezing \_\_\_\_\_  
Chronic cough \_\_\_\_\_  
Bronchitis \_\_\_\_\_  
Shortness of breath \_\_\_\_\_  
Sleeping with extra pillow to breathe easier \_\_\_\_\_  
Tuberculosis (TB) \_\_\_\_\_  
Lung cancer \_\_\_\_\_  
Blood clot in lungs (pulmonary embolus) \_\_\_\_\_

If any items were checked on the previous pages, please explain:

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Anything else we should know:

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Patient Signature \_\_\_\_\_