MEDICAL ONCOLOGY ASSOCIATES OF SAN DIEGO
(Phone) (858) - 637 – 7888 (Phone) (619) – 582 – 7888 (Fax) (858) – 637 – 7887
4060 4th Ave #440, San Diego, CA 92103
3075 Health Ctr Dr #102, San Diego, CA 92123
230 Prospect Pl #210, Coronado, CA 92118

MEDICAL HISTORY

LAST NAME ____________ FIRST ____________ MI ____ D.O.B. ____________ DATE ____________

REFERRING M.D. ______________________________

CHIEF COMPLAINT

List the problems which have led you to seek medical help now and approximately when each began:

	Problem	Date of onset
1		
2		
3		

GENERAL HEALTH AND HABITS

Characterize your current health status: ☐Excellent ☐Very Good ☐Average ☐Poor

EXERCISE

Do you exercise regularly? ☐Yes ☐No
Type of exercise(s) ____________

SMOKING

Do you smoke? ☐Yes ☐No
How many per day____________
For how many years____________
What do you smoke? ☐Cigarettes ☐Pipe
☐Cigars Other(specify)____________
How long have (had) you smoked?____________

NUTRITION

Vitamin/Mineral Supplements____________
Your appetite: ☐Excellent ☐Good ☐Fair ☐Poor
Are there foods you avoid (or limit) for health reasons?
Specify:____________

ALCOHOL/BEVERAGES

Estimate the amount of alcohol you drink regularly:
____________drinks per day ____________drinks per week
Did you formerly drink alcohol but have permanently stopped?
☐Yes ☐No
Estimate the amount of caffeinated beverages (coffee, tea, cola) you drink per day____________glasses, cups, or cans

PAST MEDICAL AND SURGICAL HISTORY

List chronologically all the surgery you have had, indicating the nature of each operation and where and when it was done. (Be accurate and complete. Consult family, friends, physicians, etc.)

	Operation	Hospital and City	Date
1			
2			
3			
4			

Have you ever been seriously injured? (If so, give details and date)____________
List chronologically all hospitalizations not already mentioned. (Do not include childbirth.)

	Reason for Hospitalization	Hospital and City	Date
1			
2			
3			

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CURRENT MEDICATIONS

List all the medications you are now taking.

Name of medicine	Strength	How often taken	When began taking

PERSONAL HISTORY

Where were you born?______________________
Have you ever lived or traveled extensively abroad? __Yes __No
If so, give details: ___________________________
____
Have you ever worked in the field of medicine, in any capacity, including volunteer, aide, clerk, or technician?
____
What is the highest level of education you have attained?
____
What inhaled chemicals or particles are you exposed to at your place of work?
____

List the areas you have lived in chronologically, giving dates:

	Area	From	To
1			
2			
3			

List your past occupations chronologically, giving dates:

	Occupation	From	To
1			
2			
3			

FAMILY HEALTH

Please give the following information about the health of your immediate family:

Relation	Age if alive	Age at death	State of health or cause of death
Mother			
Father			
Brothers and Sisters			
Spouse			

Children			

Have any blood relatives ever had any of the following? (If so, indicate relationship.)
Cancer (specify type if known) ____
Abnormal bleeding or clotting ____
“Heart Attack” ____
Alcoholism ____
Psychiatric disease or suicide ____
A disease which “runs in the family” ____

REVIEW OF SYSTEMS

	No	Yes			No	Yes
Do you have discomfort passing urine?				Stroke?		
OBSTETRIC AND GYNECOLOGICAL				Paralysis or muscular weakness?		
Have you ever had tumor(s), cyst(s), or other breast disease?				Tremor or abnormal movements?		
How many times have you been pregnant (including miscarriages)?				Difficulty with coordination?		
How many live births?				Difficulty in walking?		
At what age did you begin to menstruate?				Difficulty in speaking?		
Have you had a hysterectomy?				Double vision or loss of vision?		
Are you now taking hormones or birth control pills?				Numbness?		
When was your last Pap smear?				Difficulty with memory?		
If you are still menstruating:				Dizziness?		
When was your last period?				**MOOD**		
The one before that?				Have you recently:		
If you had menopause:				Experienced sever anxiety, panic, or phobias?		
When was your last period?				Felt excessively fatigued?		
Have you bled since?				Felt depressed?		
Last Mammogram?				Have you ever:		
HEMATOLOGY AND ONCOLOGY				Had a nervous breakdown or psychiatric care?		
Have you ever had:				Had a drug or alcohol problem?		
Anemia?				Been involved with domestic		

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				violence?		
	No	Yes			No	Yes
Bleeding or bruising tendency?				**EYES AND EARS**		
Cancer or tumor?				Have you ever had:		
X-ray or radiation treatment?				Glaucoma?		
Do you practice breast or testicular self exam?				Other major eye diseases?		
NEUROLOGICAL				Deafness?		
Have you ever had:				Abnormal noises in the ear?		
Neurological disease?				**ALLERGY AND IMMUNOLOGY**		
Frequent or recurrent headaches?				Have you ever had:		
Loss of consciousness?				Asthma?		
Convulsions or or seizures?				A reaction to penicillin?		
Head injury?				A reaction to aspirin?		
RESPIRATORY				A reaction to any other drug? (Specify)		
Have you ever had any of the following? If so, indicate when.				Date of last immunization for:		
Pleurisy				Tetanus-Diptheria (every 10 yrs.)		
Tuberculosis skin test				Pneumococcal Pneumonia (Pneumovax)		
Tuberculosis (infection or contact)				Influenza (annual -Fall)		
Asthma (wheezing)				**JOINTS**		
Chronic bronchitis				Have you ever had any of the following? If so, indicate when.		
Emphysema				Muscle pain		
Other lung trouble				Back pain		
Exposure to dangerous dust or fumes				Joint pain		
Trouble breathing				Joint swelling		
Excessive snoring				Gout		
Do you have chest pain?				Has your doctor diagnosed arthritis, rheumatism?		
Abnormal chest x-ray?				**CUTANEOUS**		
Have you ever coughed up blood?				Have you ever had:		
Do you often cough?				Skin rashes?		

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Do you often raise sputum?				Skin cancer?		
	No	Yes			No	Yes
Do you often get chest colds?				**DIGESTIVE**		
When was your last chest x-ray?				Do you often or regularly have:		
CIRCULATORY				Poor appetite?		
Have you ever had any of the following? If so, indicate when.				Trouble swallowing?		
Chest pain				Heartburn?		
Heart trouble				Regurgitation of food or bile?		
Heart attack?(coronary)				Nausea or vomiting?		
Angina pectoris				Abdominal pain?		
High cholesterol				Constipation?		
High blood pressure				Diarrhea?		
Blackouts				Has there been any change in your bowel functioning in the past 6 mos.?		
Racing of heart				Have you ever had any of the following? If so, indicate when.		
Rheumatic fever				Hiatal or esophageal hernia		
Heart failure				Duodenal or gastric ulcer		
Abnormal cardiogram				Vomiting of blood		
Swelling of your ankles				Black or tarry stools		
Have you ever taken heart or water pills?				Stool Cards		
When was your last EKG?				Yellow jaundice		
ENDOCRINOLOGY				Liver trouble or hepatitis		
Have you ever had any of the following? If so, indicate when.				Gallbladder trouble or stones		
Hormone problems				Persistent diarrhea or colitis		
Thyroid disease				Diverticulitis		
Diabetes				Parasitic infection		
Osteoporosis				Hernia		
URINARY				Other digestive disease		
Have you ever had:				When was your last colonoscopy?		
Kidney disease or nephritis						
Protein or albumin in urine						
Blood or pus in urine						

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	No	Yes				
Kidney stones						
Urinary infection						
Prostate infection						