ONCOLOGY ASSOCIATES OF SAN DIEGO

A MEDICAL GROUP

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Name: _____ Date:_____

Age: _____ Occupation:_____

The information requested in this questionnaire is important to give you the best care.
Please take the time to fill out this form completely and accurately.

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES AND OPERATIONS

- ○ Rheumatic Fever
- ○ Heart Murmur
- ○ Bleeding Disorders
- ○ Tonsillectomy
- ○ Appendectomy
- ○ Obesity

Other:_____

_____

WOMEN: Obstetric and Menstrual History:

Number of Pregnancies:_____ Did You Breastfeed? Yes_____ No____

Age at First Pregnancy:_____ Age at First Period:_____

Number of Live Births:_____ Date of Last Period:_____

Miscarriages/Abortions:_____ Obstetric Complications:_____

Birth Control? Yes_____ No_____ Estrogens? Yes_____ No_____

Breast History:

Any history of breast or ovarian cancer in the family? Yes_____ No____

If Yes, Which Side of the Family?

Mother's Side? Yes_____ No_____

Father's Side? Yes_____ No_____

Any Nipple Discharge? Yes_____ No_____ Any Nipple Changes? Yes_____ No_____

Any Trauma to the Beast? Yes_____ No_____

ADULT: Serious Illness and Hospitalizations:

☐ Cancer ☐ Heart Disease ☐ AIDS/HIV Exposure ☐ Diabetes
☐ Hepatitis ☐ Blood Transfusion ☐ Bleeding Abnormally ☐ Blood Clots
☐ Colitis ☐ Kidney Disease ☐ Blood Pressure ☐ Phlebitis ☐ Stroke

DATE ILLNESS TREATMENT

_____

_____

ADULT: Major Surgery and Serious Injuries:

DATE OPERATION or INJURY

_____

_____

_____

ALLERGIES:

Allergy to Medications:_____ None_____

Allergy to Substances::_____

MEDICATIONS YOU TAKE: List of Medications you presently use:

Drug Dose and Frequency	Drug Dose and Frequency

HABITS:

Did You or Do You Use Tobacco? Yes_____ No____ If yes, amount?_____
Did You or Do You Use Alcohol? Yes_____ No____ If yes, amount?_____
Have You Ever Been Treated for Drug Addiction? Yes___ No___ If yes, when?_____

FAMILY HISTORY: Parents, Grand Parents, Brothers and Sisters:

MEMBER	LIVING?	DECEASED?	AT AGE	ILLNESS OR CAUSE OF DEATH

Any Family History of:

☐ Obesity ☐ Lung Disease, Asthma, Emphysema
☐ Diabetes ☐ Kidney Disease
☐ High Blood Pressure ☐ Bleeding Tendency or Blood Disorder
☐ Heart Disease ☐ Breast Cancer
☐ High Blood Pressure ☐ Colon Cancer
☐ Allergy to Latex

Names of Your Doctors: Please list Doctors you currently attend with:

SPECIALTY NAME LOCATION PHONE

Family Doctor_____

Internist_____

Orthopedist_____

Gynecologist_____

Other_____

SYSTEM REVIEW: Circle All Symptoms Which You Have or Have had. Write in Any Additional Problems

HEAD, EARS NOSE AND THROAT: Stuffy Nose, Runny Nose, Hay-Fever, Sinus Trouble, Earache, Headache, Blurry Vision, Double Vision, Haloes Around Lights, Loss of Night Vision, Buzzing in Ears, Ringing in Ears, Discharge From Ears, Loss of Hearing, Dizziness, Vertigo, Loss of Balance, Sore Throat. Lump in Throat, Trouble Swallowing, Pain with Swallowing, Hoarseness.

RESPIRATORY: Cough, Wheezing, Shortness of Breath at Night, Use Two Pillows, Blood in Sputum, Out of Breath with Exertion, Wake up at Night Short of Breath, Wake up at Night Coughing or Choking, Asthma, Emphysema, Bronchitis.

CARDIO VASCULAR: Palpitations, Pounding of Heart, Skipping of heart beat, Pains in Chest, Pains in Neck Pains in Anus, Squeezing of Chest. Heart Attack, Heart Murmur, Abnormal Electrocardiogram. Irregular Heartbeat, High Blood Pressure, Pain in Legs. Cold Feet, Blue Toes, Blue Fingers, Loss of Pulses.

GASTROINTESTINAL: Heartburn, Nausea, Vomiting, Belching Fluid in Throat, Burning in Throat Food Sticking in Chest, Pains in Stomach, Burning in Stomach, Acid Stomach, Diarrhea, Constipation, Pain with Bowel Movement Blood in Stools. Hemorrhoids, Fissures, Cramps, Gassiness, Irritable Colon, Colitis.

GENITAL URNARY: Pain With Urination, Trouble Starting Urine, Trouble Stopping Urine, Small Urine Stream, Frequent Urination Getting Up at Night to Urinate, Leakage of Urine with Cough or Sneeze.

ENDOCRINE: (GLANDULAR) : Low Thyroid, Hyperthyroid, Goiter, Grave's Disease, Thyroid Nodules, X-Ray to Thyroid, Diabetes, Adrenal Gland Tumor, Frequent flushing, Frequent Heavy Sweating.

Men: Discharge from Penis Loss of Erection, Painful Erection.

Women: Vaginal Discharge, Vaginal Bleeding, Pain With Intercourse.

MUSCULOSKELITAL: Pain in Joints, Swelling in Joints, Redness of Skin Over Joints, Warm Joints, Fluid in Joints, Arthritis, Broken Bones, Sprains, Low back Pain, Hip Pain, Knee Pain, Ankle Pain, Foot Pain, Flat Feet, Slipped Disk. Herniated Disk, Sciatica.

NUROLOGICAL: Dizziness, Vertigo, Falling to the Side, Falling at Night, Numbness, Tingling, Pins & Needle Feelings, Weakness of any Muscles, Twitching of Muscles, Weakness of Grip, Shakiness, Tremor. Fainting, Convulsions, Fits, Loss of Consciousness.

PSYCHOLOGICAL: Nervousness, Anxiety, Depression, Thoughts of Suicide, Suicide Attempts, Hospitalizations for Emotional Problems, Psychiatric Treatment, Psychological Counseling.