

Name: \_\_\_\_\_  
(Last) (First) (Initial)

Home Address: \_\_\_\_\_  
(No.) (Street) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ SS #: \_\_\_\_\_

Who to contact in case of emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Phone #: \_\_\_\_\_

Marital Status: \_\_\_\_\_ No. of Children \_\_\_\_\_

Which physician referred you? \_\_\_\_\_

Reason for referral: \_\_\_\_\_

Please list any physicians that you would like to receive notice of your progress here:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

When did you first notice symptoms related to your present illness? \_\_\_\_\_

\_\_\_\_\_

What were the symptoms? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did you first see our doctor for your present illness? \_\_\_\_\_

Have you been hospitalized for this illness?  Yes  No

Which hospital? \_\_\_\_\_ When? \_\_\_\_\_

Was a biopsy performed?  Yes  No Where? \_\_\_\_\_

Have you had surgery?  Yes  No Where? \_\_\_\_\_

Have you received chemotherapy:  Yes  No Where? \_\_\_\_\_

Have you had any x-rays, CT, MRI or PET:  Yes  No Where and When? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Please list all surgery you have had and the approximate dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all other non-surgical illnesses other hospitalizations and the approximate dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all medications and dosages you are currently taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all medications to which you are allergic: \_\_\_\_\_

Have you ever received radiation, cobalt or radium treatment:  Yes  No

If yes, where? \_\_\_\_\_ when? \_\_\_\_\_

Do you smoke?  Yes  No How much? \_\_\_\_\_

Did you smoke?  Yes  No How much? \_\_\_\_\_

When did you stop smoking? \_\_\_\_\_

Do you drink alcohol:  Yes  No How much? \_\_\_\_\_

Did you ever drink alcohol?  Yes  No How much? \_\_\_\_\_

When did you stop drinking alcohol? \_\_\_\_\_

If your parents are deceased, what was their cause of death?

Mother \_\_\_\_\_ Age \_\_\_\_\_

Father \_\_\_\_\_ Age \_\_\_\_\_

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## NUTRITION

1. How is your present appetite?  Good  Fair  Poor
2. Have you experienced any weight loss?  Yes  No If yes, how much? \_\_\_\_\_
3. Do you live alone?  Yes  No If yes, is there someone who prepares the meals?  Yes  No
4. Do you have any oral or dental problems that might interfere with chewing, eating or swallowing?  Yes  No  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there any family history of cancer?  Yes  No

RELATIONSHIP	TYPE

RELATIONSHIP	TYPE

## FOR WOMEN ONLY

- Are you pregnant?  Yes  No Date of last menstrual period: \_\_\_\_\_
- No. of pregnancies: \_\_\_\_\_ No. of children: \_\_\_\_\_
- Recent vaginal bleeding?  Yes  No Discharge:  Yes  No
- Do you use birth control pills?  Yes  No Hormones?  Yes  No
- What type? \_\_\_\_\_ How long? \_\_\_\_\_

