RIVERSIDE
Cancer Care Center

NEW PATIENT HEALTH HISTORY

Patient Name_____ Today's Date _____

Birth Date _____ Age _____ Reason for today's visit_____

MEDICAL HISTORY: Have you had any of the following?

☐ None

Condition	Active Now? Yes or No	Year Started		Condition	Active Now? Yes or No	Year Started
Arthritis	☐ Yes ☐ No			Neurological Problems	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No			Liver Problems	☐ Yes ☐ No	
Bronchitis/COPD	☐ Yes ☐ No			Psychiatric	☐ Yes ☐ No	
Cancer: Site _____ (Include Skin Cancers)	☐ Yes ☐ No			Kidney Problems	☐ Yes ☐ No	
Cataracts	☐ Yes ☐ No			Indigestion/ GERD	☐ Yes ☐ No	
Colon Problems	☐ Yes ☐ No			Thyroid Problems	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No			Seizures	☐ Yes ☐ No	
Dialysis	☐ Yes ☐ No			Pneumonia	☐ Yes ☐ No	
Emphysema	☐ Yes ☐ No			Stroke	☐ Yes ☐ No	
Glaucoma	☐ Yes ☐ No			Thyroid Problems	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No			Other:	☐ Yes ☐ No	
High Blood Pressure	☐ Yes ☐ No			Other:	☐ Yes ☐ No	
High Cholesterol	☐ Yes ☐ No			Other:	☐ Yes ☐ No	

SURGICAL HISTORY/ PRIOR HOSPITALIZATIONS: Please list any surgical procedures and/or prior hospitalizations.

☐ None

_____

_____

ALLERGIES (i.e. medications, latex, tape, dye, etc)

☐ No known allergies

Allergy	Reaction

MEDICATIONS: Please list all current prescription & non-prescription medications, vitamins, etc. (If you have a list, we can make a copy)

☐ On no medications

Pharmacy: _____ Pharmacy Phone #: _____

Medication	Dose (ex: mg, mcg)	Frequency

REVIEW OF SYSTEMS: Please check the line and/or circle any symptoms you are having. Read through every section and check "No Problems" if none of the symptoms apply to you.

General
____ Weight loss
____ Fatigue/ weakness
____ Fever/chills
____ Other _____
____ No problems

Skin
____ New or change in mole
____ Rash/itching
____ Other _____
____ No problems

Breast
____ Breast lump/ pain/ nipple discharge
____ Other _____
____ No problems

Ears/Nose/Throat
____ Nosebleeds
____ Trouble swallowing
____ Frequent sore throat/ hoarseness
____ Hearing loss / hearing aids
____ Other _____
____ No problems

Cardiovascular
____ Chest pain/ discomfort
____ Rapid heartbeat
____ Heart disease
____ Other _____
____ No problems

Respiratory
____ Asthma/ emphysema
____ Short of breath with exertion
____ Cough, unproductive
____ Cough, productive Color:_____
____ Oxygen use ____ l/ min
____ Other _____
____ No problems

Gastrointestinal
____ Heartburn/ reflux/ indigestion
____ Nausea/ vomiting
____ Constipation
____ Colostomy
____ Ileostomy
____ Elimination aids
____ BM every ____ days
____ Other _____
____ No problems

Neurological
____ Seizures
____ Stroke/ TIA
____ Headache
____ Memory loss
____ Fainting
____ Dizziness
____ Numbness/ tingling
____ Unsteady gait
____ Frequent falls
____ Other _____
____ No problems

Psychiatric
____ Depression
____ Anxiety
____ Other _____
____ No problems

Women Only
____ Problems with menstrual periods
____ Post-menopausal
____ Hysterectomy
____ Date of last menstrual period _____
____ Is there any possibility you are pregnant?
____ Other _____

____ No problems

Eyes
____ Glasses/contacts
____ Change in vision/ eye pain/ redness
____ Glaucoma
____ Other _____
____ No problems

Musculoskeletal
____ Neck pain
____ Back pain
____ Arthritis
____ Other _____
____ No problems

Genitourinary
____ Leaking urine
____ Blood in urine
____ Night time urination or increase in frequency
____ Other _____
____ No problems

Endocrine
____ Thyroid problems
____ Other _____
____ No problems

Hematological/ Lymphatic
____ Swollen glands
____ Easy bruising
____ Other _____
____ No problems

Men Only
____ Prostate problems
____ Breast lump
____ Erection difficulties
____ Penis discharge
____ Sore on penis
____ Lump in testicles
____ Other _____
____ No problems

Other Problems
____ High cholesterol
____ Diabetes
____ Dialysis
____ High blood pressure
____ Other _____
____ No problems

Any other additional information: _____

Do you have:

Pacemaker? If yes, please let us make a copy of your card
Cardiologist name _____ Date of last pacemaker check _____
Internal Defibrillator? If yes, please let us make a copy of your card
Cardiologist Name _____ Date of last defibrillator check _____

TREATMENT HISTORY:

Have you had or are you currently having:

Cancer	□ Yes	□ No	If yes, type/year _____
Radiation Therapy	□ Yes	□ No	Where & when _____
Chemotherapy	□ Yes	□ No	When _____
Hormone Treatments	□ Yes	□ No	When _____

FAMILY HISTORY

Has any family member had cancer? If yes, please list TYPE of cancer & age of death (if applicable)

Father	□ Yes	□ No	_____	Age of death: _____
Mother	□ Yes	□ No	_____	Age of death: _____
Brothers	□ Yes	□ No	_____	Age of death: _____
Sisters	□ Yes	□ No	_____	Age of death: _____
Grandparents	□ Yes	□ No	_____	Age of death: _____
Children	□ Yes	□ No	_____	Age of death: _____
Other relatives	□ Yes	□ No	_____	Age of death: _____

_____

For Office Use Only:

Tobacco □ Yes □ No
Cessation □ Yes □ No
Advance Directive □ Yes □ No
Information Given? □ Yes □ No
Distress Tool Score _____