# Fitzgibbon Hospital
# Community Cancer Center

# Medical History

Name: ______________________ Date of Birth: ______________

## FAMILY HISTORY

Father ☐ Alive (Age ____) ☐ Deceased (Age ____) ☐ Cause of death: ______________ ☐ Unknown

Mother ☐ Alive (Age ____) ☐ Deceased (Age ____) ☐ Cause of death: ______________ ☐ Unknown

| | Number Alive | Approximate Age(s) | Number Deceased | Approximate Age(s) of Death | Cause of Death | |
|---|---|---|---|---|---|---|
| Brothers | | | | | | ☐ Unknown |
| Sisters | | | | | | ☐ Unknown |
| Sons | | | | | | ☐ Unknown |
| Daughters | | | | | | ☐ Unknown |

| Illnesses / Conditions | None | Father | Mother | Brothers | Sisters | Sons | Daughters | Describe |
|---|---|---|---|---|---|---|---|---|
| Colon cancer or polyps | | | | | | | | |
| Breast or ovarian cancer | | | | | | | | |
| Other type of cancer (lung, prostate, kidney, etc.) | | | | | | | | |
| Blood clots | | | | | | | | |
| Anemia or other blood problems | | | | | | | | |
| Diabetes | | | | | | | | |
| High blood pressure | | | | | | | | |
| High cholesterol or triglycerides | | | | | | | | |
| Heart disease | | | | | | | | |
| Stroke / TIA | | | | | | | | |
| Anxiety, depression or psychiatric illness | | | | | | | | |
| Tuberculosis (TB) | | | | | | | | |
| Anesthesia complications | | | | | | | | |
| Genetic disorders | | | | | | | | |
| Other - describe | | | | | | | | |

## SOCIAL HISTORY

How many years of school have you completed? ______________

Are you disabled? ☐ No ☐ Yes ⇨ ______________

Your current employment status: ☐ Employed ☐ Retired ☐ Unemployed ☐ Homemaker

Current or previous occupation: ______________

Are you married? ☐ No ☐ Yes

Do you live alone? ☐ No ☐ Yes

Have you used any of the following substances?

| Substance | Currently Use? | Previously Used? | Type / Amount / Frequency | How Long (years) | Year Stopped? |
|---|---|---|---|---|---|
| Cigarettes | ☐No ☐Yes | ☐No ☐Yes | | | |
| Other Tobacco | ☐No ☐Yes | ☐No ☐Yes | | | |
| Alcohol (beer/wine) | ☐No ☐Yes | ☐No ☐Yes | | | |
| Recreational/Street Drugs | ☐No ☐Yes | ☐No ☐Yes | | | |

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## PAST MEDICAL HISTORY

**Indicate whether you have ever had a medical problem and/or surgery related to each of the following by placing a check (✓) in the appropriate box(es). If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. Circle the appropriate choice when multiple choices are listed in a question.**

| | No Problem | Medical Problem | Surgery | Year(s) of Surgery | Describe |
|---|---|---|---|---|---|
| Eyes (cataracts, glaucoma) | ☐ | ☐ | ☐ | | |
| Ears, nose, sinuses, tonsils | ☐ | ☐ | ☐ | | |
| Thyroid or parathyroid glands | ☐ | ☐ | ☐ | | |
| Heart valves or abnormal heart rhythm | ☐ | ☐ | ☐ | | |
| Coronary (heart) arteries (angina) | ☐ | ☐ | ☐ | | |
| Arteries (aorta, arteries to head, arms, legs) | ☐ | ☐ | ☐ | | |
| Veins or blood clots in the veins | ☐ | ☐ | ☐ | | |
| Lungs | ☐ | ☐ | ☐ | | |
| Esophagus or stomach (ulcer) | ☐ | ☐ | ☐ | | |
| Bowel (small & large intestine) or appendix | ☐ | ☐ | ☐ | | |
| Liver or gallbladder (including hepatitis) | ☐ | ☐ | ☐ | | |
| Pancreas | ☐ | ☐ | ☐ | | |
| Hernia | ☐ | ☐ | ☐ | | |
| Lymph nodes or spleen | ☐ | ☐ | ☐ | | |
| Kidneys or bladder | ☐ | ☐ | ☐ | | |
| Bones, joints or muscles | ☐ | ☐ | ☐ | | |
| Back, neck or spine | ☐ | ☐ | ☐ | | |
| Brain | ☐ | ☐ | ☐ | | |
| Skin | ☐ | ☐ | ☐ | | |
| Breasts | ☐ | ☐ | ☐ | | |
| Females: uterus, tubes, ovaries | ☐ | ☐ | ☐ | | |
| Males: prostate, penis, testes, vasectomy | ☐ | ☐ | ☐ | | |

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## PAST MEDICAL HISTORY (continued)

| Have you ever had any of the following? | NO | YES | Describe the problem when appropriate |
|---|---|---|---|
| Abnormal chest x-ray | ☐ | ☐ | |
| Anesthesia complications | ☐ | ☐ | |
| Anxiety, depression or mental illness | ☐ | ☐ | |
| Blood problems (abnormal bleeding or anemia) | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Polyp or tumor removed from colon or rectum | ☐ | ☐ | |
| High blood pressure | ☐ | ☐ | |
| High cholesterol or triglycerides | ☐ | ☐ | |
| Sexual transmitted disease | ☐ | ☐ | |
| Stroke or TIA | ☐ | ☐ | |
| Treatment of alcohol and/or drug abuse | ☐ | ☐ | |
| Tuberculosis or positive skin test for TB | ☐ | ☐ | |
| Cosmetic or plastic surgery | ☐ | ☐ | |
| Blood or blood product transfusion | ☐ | ☐ | |
| Scleroderma or connective tissue disease | ☐ | ☐ | |
| Radiation (Cobalt or radioactive implants) therapy | ☐ | ☐ | |
| Chemotherapy or immunotherapy | ☐ | ☐ | |

| FEMALE PATIENTS ONLY: | NO | YES |
|---|---|---|
| Have you ever taken birth control pills or hormone replacement?________ | ☐ | ☐ |
| Have you ever had an abnormal Pap smear?________ ☐ Unknown | ☐ | ☐ |
| Have you experienced menopause or had a hysterectomy?________ | ☐ | ☐ |
| If NO: Are you concerned about your menstrual period?________ | ☐ | ☐ |
| Might you be pregnant at this time?________ | ☐ | ☐ |

Date of onset of your last menstrual period: mo:_______ yr:_______ yr:_______

Approximate date of your last Pap smear and pelvic exam: mo:_______ yr:_______ ☐ Never

Approximate date of your last mammogram: mo:_______ yr:_______ ☐ Never

Number of: Pregnancies:_______ Live Births:_______

Your age of first pregnancy:_______

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