ARCH MEDICAL SERVICES, INC.
THE CENTER FOR CANCER CARE AND RESEARCH

PATIENT MEDICAL HISTORY FORM

NAME: ____________________ **DATE:** ____________________

Birth Date: ____________________ **Age:** __________

Why are you here today: (In your own words) ____________________

____

____

Referring Doctor: ____________________ **Primary Care Doctor (if different)** ____________________

Other doctors seen in the past 12 months: ____________________

____

Surgeries: (Including Gallbladder, Hernia, etc.)

Problem (surgery): ____________________ **Hospital:** ____________________ **Year:** ______

Problem (surgery): ____________________ **Hospital:** ____________________ **Year:** ______

Problem (surgery): ____________________ **Hospital:** ____________________ **Year:** ______

Problem (surgery): ____________________ **Hospital:** ____________________ **Year:** ______

Other Hospitalizations:

Problem ____________________ **Hospital:** ____________________ **Year:** ______

Problem ____________________ **Hospital:** ____________________ **Year:** ______

Problem ____________________ **Hospital:** ____________________ **Year:** ______

Problem ____________________ **Hospital:** ____________________ **Year:** ______

NAME:____ DATE:__________________

Other Major Health Problems (Check):

Diabetes	**Yes___**	**No___**
Heart Failure	**Yes___**	**No___**
High Blood Pressure	**Yes___**	**No___**
High Cholesterol	**Yes___**	**No___**
Heart Attack/Angina	**Yes___**	**No___**
Stroke	**Yes___**	**No___**
Transfusions	**Yes___**	**No___**
HIV/AIDS Risk Factors	**Yes___**	**No___**

Others (List)

____

____

____

Have you had a: (circle)	**Colonoscopy**	**Yes**	**No**	**If yes, date____________________**
	Sigmoidoscopy	**Yes**	**No**	**If yes, date____________________**

List all medications you currently take, including dose and how often you take it (include over-the-counter medications such as vitamins, etc.).

____

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____

____

____

____

Allergies to medications? (List all and type of reaction to each, e.g. rash, nausea, etc.)

____

____

Habits: (Circle)

Alcohol:	**Every Day**	**Occasional**	**Never**		
Tobacco:	**Cigarettes**	**Pipe**	**Cigars**	**Chew**	**Never**

If cigarettes, number of packs per day_________ Length of time (years) ______________________

NAME:____ DATE:_______________

Social History: (Circle)

Married Divorced Single Widow/Widower

Working Retired Unemployed Disabled

Job Type (housewife, carpenter, etc.)____

Family History

	Living Yes/No	Age (at death if deceased)	Cancer Yes/No	Type of Cancer	Age at Cancer Diagnosis	Heart Disease Yes/No	Diabetes Yes/No
Father							
Mother							
Sister(s)							
Brother(s)							

WOMEN ONLY:

Age at 1st Menstrual Period:______

Age at 1st Pregnancy:______ Number of Pregnancies:______ Number of Children:______

Menopause (Circle): Yes No Age at Menopause: ____________

Hormone therapy (Circle): Yes No Type (circle): 1. Birth Control Pills
2. Hormone Replacement Therapy

Last Mammogram (date) __________________ Normal? (circle) Yes No

Last PAP Smear (date) ____________________ Normal? (circle) Yes No

(Form Revised 9/24/02)