CAROLINA REGIONAL CANCER CENTER

PATIENT HISTORY

Patient Label

Date ______________________

MEDICAL INFORMATION: The problem you are here is ______________________

____

SPECIFIC MEDICAL PROBLEMS:

- Diabetes ☐ no ☐ yes
- Lupus ☐ no ☐ yes
- Scleroderma ☐ no ☐ yes
- Ulcerative Colitis ☐ no ☐ yes
- Crohn's Disease ☐ no ☐ yes
- HIV Positive ☐ no ☐ yes
- Any Autoimmune Disease ☐ no ☐ yes
- Elevated Cholesterol ☐ no ☐ yes
- Arthritis ☐ no ☐ yes
- Hypertension ☐ no ☐ yes

Any other medical problems you have: ______________________

FAMILY HISTORY OF CANCER:

- ☐ Father What type? ______________________
- ☐ Mother What type? ______________________
- ☐ Brother What type? ______________________
- ☐ Sister What type? ______________________
- ☐ Grandfather What type? ______________________
- ☐ Grandmother What type? ______________________
- ☐ Other relative Who and What type? ______________________

SOCIAL HISTORY:

Marital status ______________________ Number of Children ______________________

Profession (now or past) ______________________

Alcohol Use ______________________ Smoking History ______________________

CURRENT SYMPTOMS:

- Vision ☐ no ☐ yes
- Sinuses/Nose ☐ no ☐ yes
- Hearing ☐ no ☐ yes
- Eating ☐ no ☐ yes
- Swallowing ☐ no ☐ yes
- Digestion ☐ no ☐ yes
- Heart ☐ no ☐ yes
- Lungs/Breathing ☐ no ☐ yes
- Weakness ☐ no ☐ yes
- Urination ☐ no ☐ yes
- Poor Balance ☐ no ☐ yes
- Skin ☐ no ☐ yes
- Numbness ☐ no ☐ yes
- Confusion/Disorientation ☐ no ☐ yes
- Arms and/or Legs ☐ no ☐ yes
- Impotence ☐ no ☐ yes
- Incontinence (leaking) ☐ no ☐ yes

HAVE YOU EVER HAD RADIATION TREATMENTS BEFORE? ☐ no ☐ yes

ARE YOU CLAUSTROPHOBIC? ☐ no ☐ yes

OTHER INFORMATION YOU FEEL IS IMPORTANT: ______________________

____

____

____

____