REGIONAL MEDICAL ONCOLOGY CENTER

Please fill out all sections

Patient Name: _____ **Gender:** ❑ **Male** ❑ **Female** **Date:** _____

PAST MEDICAL HISTORY: **WT:** **HT:** **T:** **P:** **BP:**

Do you have or have you ever had?

❑ Anemia	❑ Heart Disease	❑ Kidney Disease
❑ Asthma	❑ High Blood Pressure	❑ Migraines
❑ Cancer (type) _____	❑ High Cholesterol	❑ Neurological Deficits
❑ Colitis/Crohn's Disease	❑ Hepatitis/Liver Disease	❑ Pulmonary embolism/DVT
❑ COPD	❑ HIV/AIDS	❑ Rheumatoid Arthritis
❑ Diabetes	❑ Indigestion/Reflux	❑ Stroke

Other medical conditions (please list):

_____

PAST SURGICAL HISTORY:

❑ Adenoidectomy	❑ Colectomy	❑ Hysterectomy (complete)
❑ Appendectomy	❑ Gallbladder	❑ Hysterectomy (partial)
❑ Bladder	❑ Gastric Bypass	❑ Knee ___ L ___ R
❑ Cataract	❑ Hemorrhoidectomy	❑ Lumpectomy ___L ___R
❑ CABG	❑ Hip ___L ___R	❑ Mastectomy ___L ___R
❑ Carotid Endarterectomy	❑ Pacemaker	❑ Tonsillectomy
❑ C-Section	❑ Thyroidectomy	❑ Other_____

Allow RMOC to verify your MEDICATIONS electronically? ❑ Yes ❑ No

Pharmacy Name/Location: _____

SCREENING HISTORY:

Smoking Status: ❑Non-Smoker ❑Former Smoker ____ packs/day ____numbers of years smoked
❑ Current Smoker _____packs/day ____numbers of years smoked
Alcohol Use: ❑ None ❑ Social ❑ Current ____drinks/day ❑Former ____ drinks/day
Date of last colonoscopy? _____ ❑Never
Date of last bone density test? _____ ❑Never

Female History:

Last Pap Smear? _____ ❑Unknown ❑Hysterectomy
Last Mammogram? _____ ❑Unknown ❑Never
Do you perform monthly Self Breast Exams? ❑Yes ❑No

Male History:

Date of last Prostate Exam_____ ❑Unknown ❑Prostatectomy
Date of last Prostate Specific Antigen (Lab test)?_____ ❑Unknown ❑Never

IMMUNIZATION HISTORY:
Allow RMOC to verify your IMMUNIZATIONS electronically? ❑ Yes ❑ No

Date of last flu shot? _____ ❑Allergic ❑Refused
Date of pneumovax if 65 years or older? _____ ❑Allergic ❑Refused
Date of Shingles vaccine? _____ ❑Allergic ❑Refused
Date of Tdap? _____ ❑Allergic ❑Refused

FAMILY HISTORY OF CANCER? ❑ Yes ❑ No

Mother ❑ Living ❑ Deceased Age: _____ Medical History: _____
Father ❑ Living ❑ Deceased Age: _____ Medical History: _____
Sibling(s) ❑ Living ❑ Deceased Age: _____ Medical History: _____
❑ Living ❑ Deceased Age: _____ Medical History: _____

Patient Chart ID: _____ **Patient Date of Birth:**_____

REGIONAL MEDICAL ONCOLOGY CENTER

Please fill out all sections

Patient Chart ID: _____ **Patient Date of Birth:_____**

ALLERGIES:

Please list any known allergies:

_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS:

Please list name of drug, dosage, and directions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
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