REGIONAL MEDICAL ONCOLOGY CENTER

Please fill out all sections

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

PAST MEDICAL HISTORY:

Do you have or have you ever had?

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

Other medical conditions (please list):

_____

PAST SURGICAL HISTORY:

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

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 Name: _____ **Date:** _____

ALLERGIES:

Please list any known allergies:

_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS:

Please list name of drug, dosage, and directions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
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16. _____
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24. _____
25. _____

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