Coborn Cancer Center

CENTRACARE Health System

Patient Health History Form

Your Name _____ **Your Date of Birth** _____

Today's Date _____

Taking care of your health is important to us and we take this responsibility seriously! CentraCare Health System has recently transitioned your paper medical chart to an electronic version. Our number one priority in this project has been improved patient care. It is essential that this electronic medical record have all the information vital to your care and to accomplish this objective we are requesting that you complete the following information. Once your past medical and family history has been entered into the electronic record, this information need only to be reviewed and updated in the future. Please provide your best estimate if you are unable to remember specific dates or details.

Allergies

Staff: Enter into Allergy Activity

Do you have any allergies to medications or other substances?

Medication or Substance	What kind of reaction?

Medications

Staff: Enter into Medication Documentation

List any prescription or over the counter medications you take on a regular basis. Include supplements, herbal or homeopathic medications.

Current Medication(s)	Pill strength, if known	Dose	Start Date	Taking Now?	Who prescribed this?

Past Medical History Staff: Enter into History Activity or History Template on the navigator

Have you been **diagnosed** with any of the following health problems (**past or present**):

Cancer History					
	Yes	**No**		**Yes**	**No**
Bladder Cancer	☐	☐	Multiple Myeloma	☐	☐
Brain Cancer	☐	☐	Non-Hodgkin Lymphoma	☐	☐
Breast Cancer	☐	☐	Oral Cavity Cancer	☐	☐
Colon Cancer	☐	☐	Ovarian Cancer	☐	☐
Esophageal Cancer	☐	☐	Prostate Cancer	☐	☐
Hodgkin Lymphoma	☐	☐	Rectal Cancer	☐	☐
Kidney Cancer	☐	☐	Stomach Cancer	☐	☐
Leukemia	☐	☐	Testicular Cancer	☐	☐
Liver Cancer	☐	☐	Thyroid Cancer	☐	☐
Lung Cancer	☐	☐	Uterine Cancer	☐	☐
Melanoma	☐	☐		☐	☐

Other Medical History: _____

Previous Cancer Treatments					
	Yes	**No**		**Yes**	**No**
Alternative Medicine Treatment	☐	☐	Chemotherapy	☐	☐
Bone Marrow Transplant	☐	☐	Radiation Therapy	☐	☐

Other Medical History: _____

Other Medical History					
	Yes	**No**		**Yes**	**No**
Alzheimer's Disease	☐	☐	HIV/AIDS	☐	☐
Anemia or Low Hemoglobin	☐	☐	Inflammatory Bowel Disease	☐	☐
Anxiety	☐	☐	Irregular/Fast Heart Rate	☐	☐
Asthma	☐	☐	Heart Attack	☐	☐
Bladder or Urinary Infections	☐	☐	Kidney Disease	☐	☐
Blood Clots or Deep Vein Thrombosis	☐	☐	Kidney Stones	☐	☐
Chest Pain (heart related)	☐	☐	Liver Disease	☐	☐
Chronic Lung Disease	☐	☐	Lupus	☐	☐
Colitis	☐	☐	Lyme Disease	☐	☐
Congestive Heart Failure	☐	☐	Multiple Sclerosis	☐	☐
COPD	☐	☐	Osteoporosis	☐	☐
Crohn's Disease	☐	☐	Pancreatitis	☐	☐
Depression	☐	☐	Parkinson's Disease	☐	☐
Diabetes	☐	☐	Rheumatoid Arthritis	☐	☐
Gallbladder Problems	☐	☐	Schlerodema	☐	☐
Heart Attack	☐	☐	Seizures or Epilepsy	☐	☐
Heart Murmur	☐	☐	Serious Mental Health Problem	☐	☐
Hiatal Hernia	☐	☐	Thyroid Problems	☐	☐
High Blood Pressure	☐	☐	Tuberculosis	☐	☐
History of Blood Transfusion	☐	☐	Ulcers	☐	☐

Surgical History

Staff: Enter in Surgical History

What kind of surgery have you had, if any? ☐ None

Procedure or Surgery	Date of procedure	Where was the surgery done?	Any complications?

Any problems with anesthesia? ☐ No ☐ Yes, please explain: _____

☐ Any pacemakers or internal device

Family History

Staff: Enter in History Activity or within the History Template of the Visit Navigator

Use a check mark to indicate a family history or any of the following health problems. Also note the relationship of affected individual to you. Additional family members, put on back page.

☐ Adopted, no medical history for biological family members

Relationship	Name	Status	Negative/No History Of	Alcohol/Drug Problem	Anesthesia Complications	Arthritis	Asthma	Blood/Bleeding Disorders	Breast Cancer	Colon Cancer	Ovarian Cancer	Cancer (other)	Diabetes	Heart Disease	Hypertension	Lipid Problem	Genetic Disease	Kidney Disease	Mental Health	Obesity	Stroke	Thyroid	Other
Parent	Mother	☐ Living ☐ Deceased Cause: _____ Age of Cancer Diagnosis _____																					
Parent	Father	☐ Living ☐ Deceased Cause: _____ Age of Cancer Diagnosis _____																					
Grandparent	Mom's Mother	☐ Living ☐ Deceased Cause: _____ Age of Cancer Diagnosis _____																					
Grandparent	Mom's Father	☐ Living ☐ Deceased Cause: _____ Age of Cancer Diagnosis _____																					
Grandparent	Dad's Mother	☐ Living ☐ Deceased Cause: _____ Age of Cancer Diagnosis _____																					
Grandparent	Dad's Father	☐ Living ☐ Deceased Cause: _____ Age of Cancer Diagnosis _____																					

Use a check mark to indicate a family history or any of the following health problems. Also note the relationship of affected individual to you. Additional family members, put on back page.

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Sibling	☐ **Bro** ☐ **Sis**	☐ Living ☐ Deceased Cause: _____ Age of Cancer Diagnosis _____																					
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Children	☐ **Son** ☐ **Dau**	☐ Living ☐ Deceased Cause: _____ Age of Cancer Diagnosis _____																					
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Do you have any hereditary diseases in your family not documented already above? ☐ No ☐ Yes, please describe:

Health Habits & Personal Safety

Staff: Enter in History Activity or within the History Template of the Visit Navigator

Tobacco:

Are you exposed to second hand smoke on a regular basis? ☐ No ☐ Yes, at home ☐ Yes, work
Do you use tobacco products? ☐ Yes ☐ Never ☐ Quit, date _____
If yes, what type(s)? ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Snuff ☐ Pipe
If cigarettes, how many packs per day? ☐ <25 ☐ 0.5 ☐ 1.0 ☐ 1.5 ☐ 2.0 ☐ _____
If using other types of tobacco, how much per day? _____
Are you interested in quitting? ☐ Yes ☐ Not interested

Alcohol:

Alcohol use per week:
_____ Can(s) of beer _____ Drinks with 0.5 oz of alcohol _____ Glass(es) of wine _____ Shot(s)
☐ I do not drink alcohol ☐ Quit, date _____
Is your alcohol use a concern for you or others? ☐ No ☐ Yes

Drugs:

Do you currently use recreational or street drugs? ☐ No ☐ Yes
If so, what kind? _____
How many times per week do you use? _____

Sexuality

Are you sexually active? ☐ No ☐ Yes
Sexual partner(s) are ☐ Male ☐ Female
Birth Control & Infection Protection: ☐ None needed ☐ What kind? _____
Do you have any concerns about your sex life? ☐ No ☐ Yes

Advanced Directive

Do you have a health care directive? ☐ No ☐ Yes

Social Documentation

Marriage Status: _____ **Number of Children:** _____

Partner Information: Spouse or Partner's Name _____

Occupation & Education: Your Occupation: _____ Your Years of education: _____

Have you been exposed to:
Asbestos: ☐ No ☐ Yes Involuntary Smoke: ☐ No ☐ Yes Wood Dust: ☐ No ☐ Yes
Benzene: ☐ No ☐ Yes Coal Tar: ☐ No ☐ Yes Randon: ☐ No ☐ Yes
Other environmental exposure: ☐ No ☐ Yes

For Women – Obstetrical History

How many pregnancies have you had? _____ Miscarriages or pregnancy losses? _____ Premature deliveries? _____
What complications during pregnancy or childbirth, if any?
*Age at first period? _____ *Age at first pregnancy: _____ *Age at last pregnancy: _____
*Age at Menopause: _____ *Breastfeeding duration: _____
*Hormonal contraceptive use duration: _____ *Hormone replacement use duration: _____ *Hot Flashes: _____
Date of last Menses: _____ When/how long _____

Preventive Health Screening

Have you had any of the following tests done outside of CentraCare Health System? If so, please list dates.
Colonoscopy _____ Bone density (DXA scan) _____
For women: Mammogram _____ Pap smear _____ Pelvic exam _____
For men: PSA (prostate specific antigen) _____
Genetics
Have you ever had genetic testing/counseling? ☐ Yes ☐ No
If yes, describe: _____

Immunizations

Staff: Enter into Immunization Activity

Most Recent Immunization Dates, if known: Hepatitis A _____ Pneumovax _____ Influenza _____
Hepatitis B _____ Varicella (Chickenpox) _____ Tetanus (TD) _____

Spouse/Significant Other:

Does you spouse/significant other live with you? ☐ No ☐ Yes
Health of spouse/significant other? _____
Is this person willing/able to help you? ☐ No ☐ Yes
Does this person depend on you for help? ☐ No ☐ Yes

Patient Name: _____

REVIEW of SYSTEMS: Please ✓ all of the items that **currently** apply to you.

GENERAL

Normal Weight: _____
☐ Recent Weight Loss
Amount: _____
☐ Recent Weight Gain
Amount: _____
☐ Loss of Appetite
☐ Fatigue
☐ Weakness
☐ Fevers
☐ Chills
☐ Night Sweats
☐ Sleep Problems

EYES

☐ Glasses
☐ Contact Lenses
☐ Glaucoma
☐ Cataracts
☐ Double Vision
☐ Change in Vision
☐ Other Vision Problems

EARS/NOSE/THROAT

☐ Loss of Hearing
☐ Hearing Aid
☐ Ringing in Ears
☐ Other Ear Problems
☐ Nose Bleed
☐ Dentures
☐ Dental Problems
☐ Frequent Sore Throats
☐ Hoarseness
☐ Difficulty Swallowing
☐ Dry Mouth
☐ Loss of Taste
☐ Neck Stiffness
☐ Neck Pain or Swelling

CARDIOVASCULAR

☐ Pacemaker
☐ Chest Pain
☐ Irregular Heartbeat
☐ Palpitations
☐ Hypertension
☐ Sleep Sitting or Propped Up
☐ Short Breath When Lying Down
☐ Fainting Spells
☐ Leg Pain While Walking
☐ Swelling in Feet
☐ Varicose Veins
☐ Oxygen Use at Home

RESPIRATORY

☐ Shortness of Breath
☐ Difficulty Breathing
☐ Coughing
☐ Dry Cough
☐ Coughing Up Sputum
☐ Coughing Up Blood

GASTROINTESTINAL (GI)

☐ Heartburn
☐ Nausea/Upset Stomach
☐ Abdominal Pain
☐ Vomiting
☐ Jaundice
☐ Change in Bowel Habits
How Long? _____
☐ Constipation
☐ Diarrhea
☐ Blood in Stool
☐ Hemorrhoids/Fissures

GENITOURINARY (GU)

☐ Difficulty Urinating
☐ Frequent Urination
☐ Painful Urination
☐ Up at Night to Pass Urine
☐ Blood in Urine
☐ Color Change in Urine
☐ Sexual Difficulties

MUSCULOSKELETAL

☐ Leg Cramps
☐ Painful Muscles
☐ Painful Joints
☐ Physical Disabilities
☐ Gout
☐ Artificial Joints
☐ Prosthesis
Where? _____

SKIN

☐ Itching
☐ Rash
☐ Blotchy
☐ Scaling
☐ Sores
☐ Color Changes
☐ Growths (mole changes)

HEMATOLOGIC & LYMPHATIC

☐ Swollen Lymph Glands
☐ Excessive Bruising
☐ Excessive Bleeding

BREAST

☐ Pain in Breast
☐ Lump or Mass in Breast or Armpit
☐ Discharge or Bleeding from Nipple
☐ Change in Nipple
☐ Nipple Inversion
☐ Lump
☐ Surgery to Breast
☐ Change in Size, Shape or Contour of Breast
Bra Size: _____

NEUROLOGICAL

☐ Headaches
☐ Tremors
☐ Memory Loss
☐ Difficulty Finding Words
☐ Difficulty Writing
☐ Difficulty Thinking Clearly
☐ Numbness or Tingling
☐ Dizziness
☐ Loss of Consciousness
☐ Seizures
☐ Coordination
☐ Unsteady Gait

PSYCHIATRIC

☐ Nervousness
☐ Anxiety
☐ Depression
☐ Change in Personality
☐ Relationship Problems

ENDOCRINE

☐ Excessive Thirst
☐ Excessive Urination
☐ Thyroid Problems

MEN ONLY

☐ Currently Sexually Active
☐ Impotence
☐ Difficulty with Erections
☐ Penile Discharge
☐ Testicular Mass
☐ Testicular Pain