NMC Health Network

Exam Room: _____
Time In: _____
Time Out: _____
Time Spent With Patient: _____

NEW PATIENT MEDICAL HISTORY

Date _____ Patient's Name _____ Age _____

Did anyone accompany you today? If so, who? _____ Able to read English? ☐ Yes ☐ No

Usual weight _____ Have you lost weight recently? ☐ Yes ☐ No If so, how much? _____

Please list all your doctors and their specialty:

1. _____ 3. _____

2. _____ 4. _____

Do you have a cancer diagnosis? ☐ Yes ☐ No If yes, give a brief history of how your cancer was diagnosed.

_____

_____

Have you ever had radiation? ☐ Yes ☐ No If yes, when _____ where _____

Have you ever had chemotherapy? ☐ Yes ☐ No If yes, last cycle _____ where _____

Next cycle _____

HAVE YOU EXPERIENED ANY OF THESE SYMPTONS RECENTLY?

PROBLEM	YES	NO	LIST ANY COMMENTS ABOUT THIS PROBLEM YOU WANT THE DOCTOR TO KNOW ABOUT
Weak	◯	◯	
No Appetite	◯	◯	
Nausea	◯	◯	
Pain	◯	◯	Pain Scale ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 None > Mild > Moderate > Severe > Worst Location of pain: _____ Description: ☐ Dull ☐ Achy ☐ Sharp ☐ Shooting ☐ Burning

Do you take any medications to control your pain? ☐ Yes ☐ No If so, what? _____

How would you rate your pain with medication? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
None > Mild > Moderate > Severe > Worst

PROBLEM	YES	NO	LIST ANY COMMENTS ABOUT THIS PROBLEM YOU WANT THE DOCTOR TO KNOW ABOUT
Hot Flashes	◯	◯	
Night Sweats	◯	◯	
Headaches	◯	◯	
Vision Problems	◯	◯	
Difficulty Walking	◯	◯	
Speech Problems	◯	◯	
Numbness	◯	◯	
Tingling	◯	◯	
Vomiting	◯	◯	
Ear Pain	◯	◯	
Hearing Problems	◯	◯	
Ringing in the Ears	◯	◯	
Dizziness	◯	◯	
Mouth Sores	◯	◯	
Sore Throats	◯	◯	
Swallowing Problems	◯	◯	
Cough	◯	◯	
Shortness of Breath	◯	◯	
Coughing up Blood	◯	◯	
Chest Pain	◯	◯	
Swelling	◯	◯	
Breast Changes	◯	◯	

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PROBLEM	YES	NO	LIST ANY COMMENTS ABOUT THIS PROBLEM YOU WANT THE DOCTOR TO KNOW ABOUT
Stomach Pain	◯	◯	
Rectal Pain	◯	◯	
Rectal Bleeding	◯	◯	
Diarrhea	◯	◯	
Constipation	◯	◯	
Urinary Frequency	◯	◯	
Burning with Urination	◯	◯	
Leaking Urine	◯	◯	
Blood in Urine	◯	◯	
Problems with Erection	◯	◯	
Pain with Sex	◯	◯	
Vaginal Itching	◯	◯	
Vaginal Dryness	◯	◯	
Skin Problems	◯	◯	
Anxiety	◯	◯	
Depression	◯	◯	
Prostheses, Glasses, Dentures, etc	◯	◯	If yes, please describe:
Other	◯	◯	

When was your last: Colonoscopy _____ Flu Shot _____

Women: Mammograpm _____ Men: PSA blood test _____

Have you sustained any falls in the last 3 months? ☐ Yes ☐ No

Are you able to care for yourself, or do you require assistance? _____

Do you use a walker, cane, or wheelchair to ambulate? _____

What do you do for exercise (walk, bike, house chores, etc)? _____

PAST MEDICAL HISTORY

DIAGNOSIS	YES/NO	DIAGNOSIS	YES/NO
High Blood Pressure		Diabetes	
Heart Disease		Thyroid Problems	
Irregular Heartbeat		Blood Clots	
High Cholesterol		Stroke	
Lung Disease		Arthritis	
Pneumonia		Tuberculosis or Asbestosis	
Kidney Problems		Depression or Anxiety	
Sexually Transmitted Disease		Other	

PAST SURGICAL HISTORY

DIAGNOSIS	COMMENTS	DIAGNOSIS	COMMENTS

LIST ANY ALLERGIES (MEDICATIONS, FOODS, DYE)

ALLERGY	REACTION	ALLERGY	REACTION

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What pharmacy do you use? _____

SOCIAL HISTORY

Have you ever smoked cigarettes? ☐ Yes ☐ No If so, how long? _____ Packs per day? _____

Do you currently smoke cigarettes? ☐ Yes ☐ No If not, when did you quit? _____

Do you or have you ever dipped snuff/chew tobacco? ☐ Yes ☐ No If so, how long? _____

Do you or have you ever drank alcohol? ☐ Yes ☐ No If so, how long? _____ How much? _____

Do you or have you ever used marijuana or other drugs? ☐ Yes ☐ No If so, what drug? _____

Do you work? ☐ Yes ☐ No If so, where? _____ Are you on medical leave? ☐ Yes ☐ No

Are you retired or disabled? _____

Cell phone numbers _____

Emergency Contact _____ Phone Number: _____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you have children? ☐ Yes ☐ No If so, how many? _____ Phone Numbers: _____

Do you have a living will? ☐ Yes ☐ No If so, we need a copy. If not, would you like one? ☐ Yes ☐ No

Religious Affiliation: _____ Have you ever been in the military? ☐ Yes ☐ No

Occupation: _____

Have you ever had any hazardous occupational exposures? If so, what? _____

What is your highest level of education? _____

WHO MAY WE RELEASE INFORMATION TO?

Please list: _____

IS THERE ANYONE YOU SPECIFICALLY *DO NOT* WANT INFORMATION RELEASED TO?

Please list: _____

FAMILY HISTORY

FAMILY MEMBER	MEDICAL PROBLEM	DECEASED	LIVING
Mother			
Father			
Brother #1			
Brother #2			
Brother #3			
Brother #4			
Brother #5			
Sister #1			
Sister #2			
Sister #3			
Sister #4			

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FAMILY HISTORY

FAMILY MEMBER	MEDICAL PROBLEM	DECEASED	LIVING
Sister #5			
Spouse			
Child #1			
Child #2			
Child #3			
Child #4			
Others			

Does any type of cancer run in your family? If yes, please list: _____

WHAT QUESTIONS DO YOU HAVE ABOUT YOUR CANCER AND RADIATION?
DO YOU HAVE ANY OTHER COMMENTS FOR THE DOCTOR?

_____

_____

_____

_____

_____

Patient's Signature or Responsible Party Date

DO NOT WRITE ANYTHING PAST THIS BOX. FOR OFFICE USE ONLY

COMMENTS

Blood Pressure: Home Meds/Dossage/Frequency Taken

Temp:

Pulse:

Resp:

O2 Sat:

Weight:

Height:

Does this patient have a diagnosis of prostate cancer? ☐ Yes ☐ No If yes, have they had a bone scan? ☐ Yes ☐ No

Does this patient have a diagnosis of breast cancer? ☐ Yes ☐ No If yes, hormone therapy? ☐ Yes ☐ No

_____

_____

_____

_____

_____

_____

Reviewed by Date

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