HELEN G. NASSIF COMMUNITY CANCER CENTER *of Iowa*

Today's Date: ______ **HEALTH HISTORY AND INFORMATION FORM**

First Name ______ Last Name ______ Nickname ______

Date of Birth ______ Age ______ Soc. Sec. #: ______ Gender: ☐Male ☐Female Pregnant? ☐Yes ☐No

Home/Cell/Work Number: ______ Home/Cell/Work Number: ______ Email ______

Address ______ City ______ State ______ Zip ______

Insurance Policyholder's Name: ______ DOB: ______ Soc. Sec. # ______ Employer: ______

Emergency Contact: ______ Relationship: ______ Phone Number: ______

Family Physician ______ Referring Physician ______

Facility Preference: ☐ Mercy Medical Center (Cedar Rapids) ☐St. Luke's Hospital ☐Surgery Center Cedar Rapids ☐RCI ☐Weland ☐PCI Imaging/Lab

Reason for today's appointment (symptoms, onset, duration) ______

MEDICATIONS: List all medications you have been taking. Please include over the counter and any supplements; list dosages and frequency.

Name of Medication (☐See attached list for additional medications or copy of list.)	Dose	Frequency

ALLERGIES: Please list any allergies.

Drug	Describe Reaction	Other *(seasonal, food, etc.)*	Describe Reaction

Do you have sensitivity to Latex? ☐Yes ☐No Describe Reaction: ______

PAST HOSPITALIZATION, SURGERIES, OR INJURIES:

Hospitalization for:	When:	Where:

Please check any previous surgeries you have had:

☐Appendix ☐Colon ☐Heart ☐Kidney ☐Neck ☐Throat ☐Vasectomy
☐Bladder ☐Ear ☐Hernia Repair ☐Lung ☐Prostate ☐Tonsillectomy
☐Cataract ☐Gallbladder ☐Joint Replacement ☐Nasal/Sinus ☐Testicle ☐Urinary Stone
☐Other (please describe) ______

PAST HEALTH HISTORY: *(Check all that apply)*

☐Arthritis ☐Eye Conditions ☐Kidney Disease ☐Obstructive Sleep Apnea ☐Stroke
☐Blood Clots ☐Heart Disease ☐Liver Disease/Hepatitis ☐Received Blood in Past ☐Thyroid Disorder
☐Cancer/Type ______ ☐High Blood Pressure ☐Lung Disease/Asthma ☐Stomach/Intestinal Problems ☐Tuberculosis
☐Diabetes Mellitus ☐High Cholesterol or Lipids ☐MRSA/VRE ☐Ulcers

Other Medical Conditions (please list): ______

SOCIAL HISTORY:

Occupation: ______
☐Retired
☐Currently on Disability
☐Working Full Time
☐Working Part Time
☐Unemployed
If employed, where do you work: ______

Marital Status:
☐Single
☐Currently Married/Partnered
☐Divorced
☐Widowed
Spouse/Partner Name: ______

Diet & Caffeine Use:
Do you use caffeine? ☐Yes ☐No
How much? ______
Daily fruit/vegetable intake? ______

SOCIAL HISTORY *(continued)*:

Exercise Habits:
- ☐ Exercise Regularly?
- Type/frequency? ________________
- ☐ Exercise Occasionally
- ☐ Exercise Rarely
- ☐ Do Not Exercise

Alcohol/Drug Use:
- Do you use alcohol? ☐ Yes ☐ No
- How much? ____________________________
- Have you used drugs for non-medicinal purposes? ☐ Yes ☐ No

Tobacco Use:
- ☐ Current Smoker
- How much/how long? ________________________
- ☐ Chewing Tobacco
- ☐ Former Smoker/Date Quit______
- How much/how long? ________________________

FAMILY HISTORY: Has any member of your family (not to include spouse or in-laws) ever had the following conditions. If yes, indicate family member.

		Family Member			Family Member
☐ Yes ☐ No	Arthritis	______	☐ Yes ☐ No	High Blood Pressure	______
☐ Yes ☐ No	Cancer (include type)	______	☐ Yes ☐ No	Kidney Disease	______
☐ Yes ☐ No	Diabetes Mellitus	______	☐ Yes ☐ No	Lung Disease (COPD)	______
☐ Yes ☐ No	Eye Conditions	______	☐ Yes ☐ No	Stroke	______
☐ Yes ☐ No	Heart Disease	______	☐ Yes ☐ No	Stomach/Intestinal Problems	______
☐ Yes ☐ No	High Cholesterol/Lipids	______	☐ Yes ☐ No	Ulcers	______
☐ Yes ☐ No	Liver Disease/Hepatitis	______	☐ Yes ☐ No	TB / Other Infectious Disease	______

☐ Unable to obtain family history due to adoption or other circumstances.

Please share the following information regarding your immediate family (i.e. father, mother, children, brothers, and sisters.)

Family Member	Alive/Year Born	Deceased/Age at Death	Cause of Death
Father			
Mother			

REVIEW OF SYSTEMS: Please **check** all symptoms **you** have experienced in the last MONTH.

Constitutional/General
- ☐ Fever
- ☐ Chills
- ☐ Heavy Sweating/Night Sweats
- ☐ Loss of Appetite
- ☐ Sleep Disturbances
- ☐ Unexplained Weight Loss/Gain
- ☐ Other: ________________

Eyes
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Wear Glasses
- ☐ Other: ________________

Ear/Nose/Throat
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Nasal Congestion/Sinus Issues
- ☐ Hearing Loss
- ☐ Other: ________________

Respiratory
- ☐ Cough
- ☐ COPD
- ☐ Wheezing
- ☐ Recurrent Upper Respiratory Infections
- ☐ Shortness of Breath
- ☐ Other: ________________

Cardiovascular
- ☐ Chest Pain or Discomfort
- ☐ Swelling of Feet, Ankles or Legs
- ☐ Irregular Heart Beat
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Palpitations
- ☐ Varicose Veins
- ☐ Other: ________________

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Indigestion or Heartburn
- ☐ Blood in Stools
- ☐ Change in Bowel Habits
- ☐ Rectal Bleeding
- ☐ Diarrhea
- ☐ Constipation
- ☐ Swallowing Difficulties
- ☐ Other: ________________

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Other: ________________

Genitourinary
- ☐ Painful Urination
- ☐ Urinary Frequency
- ☐ Loss of Urinary Control
- ☐ Enlarged Prostate
- ☐ Difficulty Urinating
- ☐ Other: ________________

Skin
- ☐ Skin Rash
- ☐ Itching
- ☐ Discoloration of the Skin
- ☐ Lumps or Masses
- ☐ Other: ________________

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Back Pain
- ☐ Limitation of Motion
- ☐ Neck Pain
- ☐ Pain with Walking
- ☐ Other: ________________

Endocrine
- ☐ Excessive Thirst or Fluid Intake
- ☐ Temperature Intolerance
- ☐ Feeling Tired (Fatigue)
- ☐ Hot Flashes
- ☐ Other: ________________

Hematologic/Lymphatic
- ☐ Swollen Glands
- ☐ Blood Clotting Problem
- ☐ Easy Bruising
- ☐ Bleeding Tendencies
- ☐ Other: ________________

Neurological
- ☐ Tremors
- ☐ Dizzy Spells
- ☐ Numbness or Tingling
- ☐ Headache
- ☐ Unsteady Gait
- ☐ Feeling Weak
- ☐ Convulsions/Seizure
- ☐ Other: ________________

This Space is Intentionally Blank for Additional Comments:

Patient Signature: ________________________________

Date: ________________________________