



DATE: _____

PATIENT INFORMATION & HISTORY

Patient Name: _____

Do you live with someone else? Y N If so, with whom? _____

Name of Spouse: _____

Address/Phone if different than your own

Do you live in Florida full time? Y N If no, when are you in Florida? _____

Other Residence: _____ City: _____ State: _____ Zip: _____

Nearest Relative not living with you: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship: _____ Phone: _____

Your Occupation: _____ Are you retired? Y N
(if retired, your occupation prior to retirement)

Will you need transportation assistance to the Cancer Center? Y N

Do you have any financial concerns?

Social History:

Place of birth: _____ Where have you lived most of your life? _____

List anyone involved in your care: _____

Have you had radiation therapy before? _____ If yes, when, where, (city, state, name of facility) _____

Religious preference: _____

Alcohol History:

Do you drink beer, wine, or other alcohol products? _____ If so, what kind and how much? _____

Age started: _____ Age stopped: _____

Tobacco History:

Have you every used any tobacco products? _____

Please circle which ones: cigarettes pipe cigar chew snuff

Age started: _____ Age stopped: _____ Most used per day: _____

Family History:

| Relation | Age | State of health | Cancer? | Cause of death | Age at death |
|------------------|-----|-----------------|---------|----------------|--------------|
| Father | | | | | |
| Mother | | | | | |
| Spouse | | | | | |
| Brothers/Sisters | | | | | |
| | | | | | |
| | | | | | |
| Children | | | | | |
| | | | | | |
| | | | | | |

Are you **ALLERGIC** to any medications, insects, or foods? Y N

If yes, which ones? _____

Have you ever had radiation therapy? Y N If yes, to what area(s) of your body, when, where, and how many treatments?

Have you ever had chemotherapy? Y N If yes, what drugs, when, where, and how many treatments?

Do you have, or have you ever had any of the following conditions/illnesses? If so, please specify.

- | | |
|--|--|
| <input type="checkbox"/> Cancer (including skin cancers) _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Liver disease _____ |
| <input type="checkbox"/> Migraines _____ | <input type="checkbox"/> Gallstones _____ |
| <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Ulcer _____ |
| <input type="checkbox"/> Mental illness _____ | <input type="checkbox"/> Reflux disease _____ |
| <input type="checkbox"/> Vision Problems _____ | <input type="checkbox"/> Lactose intolerance _____ |
| <input type="checkbox"/> Hearing problems _____ | <input type="checkbox"/> GI bleeding _____ |
| <input type="checkbox"/> Thyroid problems _____ | <input type="checkbox"/> Hiatal hernia _____ |
| <input type="checkbox"/> Mouth or throat problems _____ | <input type="checkbox"/> Hemorrhoids _____ |
| <input type="checkbox"/> Seasonal allergies _____ | <input type="checkbox"/> Diverticulosis/Diverticulitis _____ |
| <input type="checkbox"/> Heart attack _____ | <input type="checkbox"/> Irritable bowel _____ |
| <input type="checkbox"/> Angina _____ | <input type="checkbox"/> Other bowel problems _____ |
| <input type="checkbox"/> Irregular heart beats _____ | <input type="checkbox"/> Kidney stones _____ |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Bladder infections _____ |
| <input type="checkbox"/> Congestive heart failure _____ | <input type="checkbox"/> Enlarged prostate _____ |
| <input type="checkbox"/> Pacemaker _____ | <input type="checkbox"/> Prostatitis _____ |
| <input type="checkbox"/> Free bleeding _____ | <input type="checkbox"/> Prostate surgery _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Female problems _____ |
| <input type="checkbox"/> Other blood disorders _____ | <input type="checkbox"/> Collagen disorders _____ |
| <input type="checkbox"/> Aneurysms _____ | <input type="checkbox"/> Other autoimmune disorders _____ |
| <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Chronic bronchitis _____ | <input type="checkbox"/> Osteoarthritis _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Rheumatoid arthritis _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Bone problems _____ |
| <input type="checkbox"/> Other lung problems _____ | <input type="checkbox"/> Fractures _____ |
| | <input type="checkbox"/> Muscle problems _____ |

