CAROLINA ONCOLOGY ASSOCIATES, P.A.

COMPREHENSIVE PATIENT HISTORY FORM

Patient Name: ____ **Today's Date:** __________________

List Medications you are currently taking:

1)_______________________ ___________________________________

2)____________________ _____________________________________

3)____________________________ _____________________________

4)_______________________ ___________________________________

5)________________________________ ________________________

6)_________________________________ _______________________

7)____

Have you ever had the following?

Diabetes………………..	yes	no
Hypertension…………...	yes	no
Cancer………………..…	yes	no
Stroke…………………..	yes	no
Heart trouble…………...	yes	no
Arthritis/gout…………...	yes	no
Convulsions…………….	yes	no
Bleeding tendency………	yes	no
Acute infections…………	yes	no
Venereal disease…………	yes	no
Shortness of Breath………	yes	no
Claustrophobic…………..	yes	no
Metal in Body……………	yes	no
Implants…………………	yes	no

Please list any Allergies you have: ______________________________

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____

List previous hospitalizations/Surgeries/Serious Injuries	**When**

Patient Social History

Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed

Use of alcohol: ___Never ___Rarely ___Moderate ___Daily

Use of tobacco: ___Never ___Previously but quit ___Current-# packs/day_____

Use of Drugs: ___Never ___Type/Frequency__________________________

Excessive exposure at home or work to: ___Fumes ___Dust ___Solvents ___Noise

Family Medical History

	Age	**Diseases**	**If Deceased, Cause of Death**
Father			
Mother			
Siblings			
Spouse			
Children			