NEW PATIENT HISTORY FORM – PIEDMONT ONCOLOGY SPECIALISTS

Name: ____ **Date of Birth:** _________________________

Consulting / Referring Physician (Who sent you to our practice?) _________________________________

Allergies: ____

CURRENT MEDICATIONS: - List all prescription, over-the-counter, or "natural"/ herbal medications.
- Please list name, dose, and how often taken.

____ ____
____ ____
____ ____
____ ____

Medical Illnesses: Do you have any of the following:

___ High blood pressure

___ Diabetes

___ Heart attack / Heart failure

___ Atrial fib (irregular heart)

___ Emphysema / Bronchitis

___ Arthritis or Gout

___ Thyroid disease

___ Stroke

___ Liver disease

___ High cholesterol

___ Depression

___ Kidney disease

Previous surgeries/hospitalizations: (please include year and Doctor, if known)

____ ____
____ ____
____ ____

FAMILY HISTORY:

	Alive	Deceased	Medical problems	Age now or age when deceased
Mother				
Father				
Sister / Brother				
Sister / Brother				
Sister / Brother				
Other				
Other				

Health Habits and Social History:

Tobacco use: ☐ Never ☐ Previously/Quit? When? ____________ ☐ Currently smoke (packs per day ________)

Alcohol use: ☐ Never ☐ Previously/Quit? When? ____________ ☐ Currently (how much________________)

Marital status: ☐ married ☐ single ☐ widowed Number of children: ____________

Who lives with you? _____________________________ Current or Previous work _________________________

HEALTH HISTORY: Do you have or have you ever had any of the following:

GENERAL / CONSTITUTIONAL	**YES**	**NO**	**Comments** (physician)
Unintentional weight loss	___	___	
Decreased appetite	___	___	
Extreme fatigue	___	___	
Fever / chills / night sweats	___	___	
EAR / NOSE / THROAT / EYE			
Glaucoma, cataracts, vision problems	___	___	
Frequent ear or sinus infections	___	___	
Recent hoarseness or voice change	___	___	
Hearing loss / Ringing in Ears	___	___	
HEART / CIRCULATION			
Chest pain / angina	___	___	
Heart attack / heart failure	___	___	
Irregular heart beat / palpitations	___	___	
Persistent swelling in hand or feet	___	___	
PULMONARY / LUNGS			
Shortness of breath (at rest / with activity)	___	___	
Coughing up blood	___	___	
Asthma, bronchitis, emphysema	___	___	
Stop breathing when sleep (sleep apnea)	___	___	
Pneumonia	___	___	
GI / LIVER / ENDOCRINE			
Jaundice or Hepatitis	___	___	
Ulcers or gastritis	___	___	
Black or bloody stools	___	___	
Frequent or persistent nausea or vomiting	___	___	
KIDNEY / BLADDER			
Blood in urine very dark urine	___	___	
Kidney stones, infections, or failure	___	___	
Difficulty or burning with urination	___	___	
REPRODUCTIVE / BREAST			
Age at first menses _____ Age at menopause ___________			
Last menstrual period date: _____________			
Last mammogram date: _____________			
Prior Birth Control	___	___	
Hormone use after menopause	___	___	
Sexually transmitted disease	___	___	
Breast lump or Discharge from nipple	___	___	
NEUROLOGIC			
Frequent, severe, or worsening headaches	___	___	
Convulsions or seizures	___	___	
Confusion or disorientation	___	___	
Numbness / Tingling in hands or feet	___	___	
MUSCULOSKELETAL			
Arthritis or joint pain	___	___	
Recent/new back or bone pain	___	___	
Limited movement or paralysis	___	___	
HEMATOLOGIC			
Severe bleeding or bruising problems	___	___	
Previous blood transfusion	___	___	
Blood clots in legs or lungs	___	___	