Winter Haven Hospital
CASSIDY CANCER CENTER
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PATIENT HISTORY FORM

Patient Name:_____ **DOB:**_____

Past Medical History

Have you ever had a heart attack or other heart problems?	Yes	No
Have you ever had a stroke?	Yes	No
Do you have asthma, emphysema, or chromic lung disease?	Yes	No
Do you have stomach ulcers or peptic ulcer disease?	Yes	No
Do you have diabetes or high blood sugar?	Yes	No
Do you have high blood pressure?	Yes	No
Have you ever had any kind of liver disease?	Yes	No
Have you ever had any kind of kidney disease?	Yes	No
Have you had any other medical problems?	Yes	No

If yes, please provide the following details:

Problem _____ Date _____ Details _____ Treatment_____

Problem _____ Date _____ Details _____ Treatment_____

Problem _____ Date _____ Details _____ Treatment_____

Do you have a personal history of cancer? Yes No

If yes, please complete the following information:

Cancer #1: _____ Date of Diagnosis: _____ Treatment Date: _____ Status: _____

Cancer #2: _____ Date of Diagnosis: _____ Treatment Date: _____ Status: _____

Past Procedure/Surgical History: (i.e., any operations and approximate dates)

Name _____ Procedure description _____ Date _____

Name _____ Procedure description _____ Date _____

Name _____ Procedure description _____ Date _____

Preventive Medicine - Last Test Dates:

Mammogram: _____ Pap Smear: _____ Bone Densitometry: _____

PSA: _____ Skin Screening: _____ Colorectal Screening: _____

Gynecologic History:

Age at first starting periods _____years

Age of first pregnancy _____years

How many pregnancies _____ How many children do you have? _____

Have you ever used birth control pills? Yes No

If yes, how many years in all _____years

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Gynecologic History: (continued)

Any use of fertility drugs? Yes No

History of breast feeding? Yes No
If yes, how long in all 6 months or less 6 months to 1 year more than 1 year

Any prior breast biopsies? Yes No How many? _____

Age at menopause _____years

Any use of hormone replacement therapy? Yes No
If yes, how many years? 5 years or less 5-10 years more than 10 years

Family History:

Has any family member been diagnosed with any type of cancer (including leukemia or lymphoma)? **Y N**

Has any family member been diagnosed with a blood disease (anemia, myelodysplasia, blood clotting problems)? **Y N**

Is there any family history of high blood pressure, diabetes, or heart disease? **Y N**

Has any family member had any other major illness? **Y N**

If yes to any of the above questions, please list family member(s) and disease below with their age at the time of diagnosis, if known:

Relation	Current Status	Age at Dx	Type of Cancer or Blood Disease
Mother	A / D / UNK	_____	_____
Maternal Grandmother	A / D / UNK	_____	_____
Maternal Grandfather	A / D / UNK	_____	_____
Father	A / D / UNK	_____	_____
Paternal Grandmother	A / D / UNK	_____	_____
Paternal Grandfather	A / D / UNK	_____	_____
Sister	A / D / UNK	_____	_____
Sister	A / D / UNK	_____	_____
Sister	A / D / UNK	_____	_____
Sister	A / D / UNK	_____	_____
Brother	A / D / UNK	_____	_____
Brother	A / D / UNK	_____	_____
Brother	A / D / UNK	_____	_____
Brother	A / D / UNK	_____	_____

Social History:

Have you ever smoked cigarettes? **Y N** If yes, how long? _____ Are you still smoking? **Y N**

Do you drink alcoholic beverages? **Y N** If yes, what type? **wine beer liquor**
If yes, how long? _____
If yes, how much? **1-2 per day 3-4 per day 5+ per day**

Allergies: (describe your reactions)

_____ reaction: _____

_____ reaction: _____

_____ reaction: _____

_____ reaction: _____

_____ reaction: _____

_____ reaction: _____

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Current Medications: (list all medicines and dosages)

_____ dose: _____ frequency: _____ per **day / week / month**
_____ dose: _____ frequency: _____ per **day / week / month**
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_____ dose: _____ frequency: _____ per **day / week / month**
_____ dose: _____ frequency: _____ per **day / week / month**

Previous Medications

_____ date discontinued: _____
_____ date discontinued: _____
_____ date discontinued: _____
_____ date discontinued: _____
_____ date discontinued: _____

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