Capital Health Medical Center - Hopewell
NEUROSURGICAL-ONCOLOGY
Patient History

Please take a few minutes and complete the following questions before you see the doctors so that we may learn a bit more about you. This will allow your doctors to spend less time asking general questions and more time focusing on your problem and treatment options. Thank you for your assistance. Please bring this completed form with you to your appointment.

Patient Name _____ **Date of Birth** _____

MR# _____ **Date of Service** _____
(Office use Only – Do not Complete) *(Office use Only – Do not Complete)*

Usual Living Conditions/Arrangements _____

What is your occupation? _____

Referring Physician_____ Primary Physician_____

Other Physicians you would like reports sent to (Name/Address):

_____

_____

Do you have any transportation needs: _____

Have you had prior radiation treatments? _____

If so, what area was treated? _____ at what facility?_____

Are you currently on a clinical trial? _____ If yes, explain: _____

Allergies: _____ **Reaction:** _____

List current prescriptions, over the counter drugs, vitamins, supplements and herbal preparations:

Name of Medication Dose Frequency

_____

_____

_____

_____

MEDICAL HISTORY

Do you have or have you had?

	Yes	No		Yes	No		Yes	No
Diabetes			Lung Problems			Regional Enteritis		
High Blood Pressure			Kidney Disease			Hepatitis		
Heart Problems			Gout			Jaundice		
Stroke			Stomach Problems			Cancer		
Rheumatic Fever			Gallbladder Problems			Hormone Therapy		
Bleeding Problems			Colitis or Diverticulosis			Chemotherapy		
Anemia			Crohn's Disease			Radiation		
Asthma			Lupus			Scleroderma		
Seizures			Respiratory Problems			Arthritis		
Heart Murmurs			Thyroid Problems			Cholesterol		

Other _____

HOSPITALIZATIONS (Please include illnesses, injuries and surgeries)

_____ _____ _____
Reason **Date** **Location**

_____ _____ _____
Reason **Date** **Location**

_____ _____ _____
Reason **Date** **Location**

FAMILY HISTORY

Relationship	Age	Alive?		
Mother		**Yes**	**No**	**Major Illness/Cause of Death**
Father				
Sibling				
Sibling				
Sibling				
Child				
Child				
Child				

Has anyone in your family had?

Disease:	Yes	No	What type:
Cancer			
Heart Disease			
Liver Disease			
Lung Disease			
Kidney Disease			
Intestinal or Colon problems			
Connective Tissue disease			

SOCIAL HISTORY

Question	Yes	No	Amount
Do you drink alcohol?			
Do you use tobacco?			

Please complete the following questions:

		Yes	No
Have you noticed any recent changes with: (Constitutional)	Weight gain or weight loss		
	Feeling too hot or too cold		
	Always feeling hungry or thirsty		
	Problems with sleeping		
Do you have problems with (Head and Neck)	Headaches		
	Dizziness or lightheadedness		
	Thyroid problems		
	Lumps or swelling in the neck or shoulder		
	Sore throat		
	Swallowing		
	Soreness of the neck or shoulder		
Do you have problems with (Eyes)	Recent changes in vision		
	Blurred or double vision		
	Cataracts		
	Glaucoma		
	Eye Infections		
	Do you wear glasses or contact lenses		
Do you have problems with (Ears, Nose and Throat)	Changes in hearing		
	Buzzing or ringing in the ears		
	Frequent earaches or ear infections		
	Motion sickness		
	Seasonal Allergies		
	Frequent sinus problems or colds		
	Recurrent nose bleeds		
	Mouth pain or difficult chewing		
	Bleeding gums or mouth sores		
	Taste change		
	Hoarse voice or difficulty talking		
	Do you wear dentures		
Do you have problems with (Respiratory System)	Asthma		
	Tuberculosis		
	Bronchitis or pneumonia		
	Difficult or painful breathing		
	Shortness of breath at rest		
	Cough		
	Night sweats		
	How many blocks can you walk before you are out of breath?		
	Has this changed recently?		
	Can you climb a flight of stairs without resting?		
	On how many pillows do you sleep?		

		Yes	No
(Respiratory System Continued)	Have you had a cough that lasted more than 2 weeks?		
	Have you coughed up phlegm daily for more than 2 weeks?		
	If yes, what color was the phlegm?		
	Have you had a skin test for TB		
	What were the results?	Positive	Negative
Do you have problems with (Cardiovascular System)	Chest pain		
	Palpitations or irregular heart beat		
	Heart murmur		
	Heart failure		
	Ankle swelling		
	High Cholesterol		
Do you have problems with (Gastrointestinal System)	Nausea or vomiting		
	Vomiting blood		
	Abdominal Pain		
	Constipation		
	Black stools		
	Blood in stools		
	Diarrhea		
	Does food ever get stuck, come back up or make you gag?		
	How many bowel movements do you have per day?		
Do you have problems with (Musculoskeletal System)	Bone or joint pain		
	Joint swelling or stiffness		
	Muscle pain or weakness		
	Sciatica		
	Broken bones		
	Have you ever been told that you have lupus or arthritis?		
Do you have problems with (Neurological System)	Weakness in the arms or legs		
	Changes in coordination or balance		
	Paralysis or numbness		
	Shaking or tremors		
	Head injury		
	Loss of consciousness or passing out		
	Seizures or fits		
	Difficulty in working with numbers		
	Difficulty thinking of words		
	Difficulty speaking		
	Changes in memory		
	Changes in handwriting		
	Difficulty in holding a pen, pencil or cup		
Do you have problems with (Skin)	Itching or burning of the skin		
	Easy bruising or bleeding of the skin		
	Sores or rashes		
Do you have problems with (Mood)	Lack of concentration or memory		
	Difficulty relaxing		
	Loss of temper		
	Being annoyed by little things		
	Excessive worrying		
	Excessive crying		
	Change in personality		
Do you have problems with (Genitourinary System)	Painful or frequent urination		
	Difficulty emptying your bladder		
	Split stream or difficulty controlling urination		

(Genitourinary System continued	Difficulty starting urination		
	Urgency to urinate without warning		
	Dribbling or loss of control of urine		
	Blood in urine		
	Kidney stones		
	Venereal Disease (VD)		
	Venereal Warts		
	Do you experience nighttime urination?		
	Do you ever urinate and then have to go again in less than ½ hour?		

For Men:

Have you noticed any change in sexual function over the last two years?	**Yes**	**No**
Date of last rectal examination		
Date of last physical examination		

For Women:

	Yes	**No**
Have you ever been pregnant?		
How many times?		
Number of children?		
Did you have any problems with pregnancy?		
Have you gone through menopause?		
At what age?		
Have you had any bleeding or discharge from the vagina?		
Have you ever had any operations or infections of the uterus, fallopian tubes or ovaries?		
Do you have any lumps, swelling or tenderness of the breasts?		
Do you have pain or bleeding with intercourse?		
Date of last pelvic exam		
Date of last PAP smear		
Date of last breast exam		
Date of last mammogram		
Date of last physical exam		

Please do not write below this line

For Physician Use only

☐ **All other systems are negative.**
☐ **Review of systems unobtainable.**
Reason _____
☐**History obtained from:** _____
☐**No other source available.**
(Problem Pertinent = 1 system, Extended + 2 to 9 systems; Complete = 10+ systems)

_____ _____

Attending Physician's Signature **Date**