Women's Cancer Care Associates, LLC Initial Patient History and Physical

Patient Name: ______________________ Date of Birth: ______/______/______
Prefers to be Called: ______________ Gender Identity: __________ Preferred Pronouns: __________

OUTSIDE PHYSICIANS

Primary Doctor: ______________________ Phone: ______________
OBGYN: ______________________ Phone: ______________
Cardiologist: ______________________ Phone: ______________
Other Doctors: ______________________ Phone: ______________
______________________ Phone: ______________
______________________ Phone: ______________

SOCIAL HISTORY

MARITAL STATUS
☐ Single ☐ Married
☐ Separated ☐ Divorced ☐ Widowed
☐ Significant Other/Domestic Partner

LIVING ARRANGEMENTS
☐ Alone ☐ Spouse/Significant Other ☐ Children
☐ Facility/Supervised Living
☐ Other: ______________________

NEXT OF KIN
Name: ______________________ Phone: ______________ Relationship: ______________

EMPLOYMENT
Currently Employed: ☐ Yes ☐ No Employer: ______________ Occupation: ______________

TOBACCO USE
☐ I have never smoked
☐ I am an ex-smoker who quit __________(year)
☐ I currently smoke ________ cigarettes or ________ packs/day

DRUG/ALCOHOL USE
☐ I do not drink alcohol ☐ I do not use street drugs
☐ I drink alcohol: how often __________ how much __________
☐ I used drugs: type:______________when______________
☐ I currently use drugs:type ______________________

BIOLOGICAL FAMILY HISTORY

	Present Age	Age at Death	Present Health Condition or Cause of Death
Father			
Mother			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			

Do any other members of your family have a history of cancer (aunts, uncles, cousins, grandparents)? If yes, please explain:
____
____
____

ADVANCE DIRECTIVES

I have a ☐ Living Will ☐ Healthcare Proxy ☐ MOLST *__Please give copy to office__*
Agent's Name: ______________________________

Women's Cancer Care Associates, LLC Initial Patient History and Physical

Patient Name: ______________________________

MEDICAL HISTORY

ALLERGIES

☐ I have no known allergies
☐ I am allergic to ______________________
What happens (rash, etc)?______________________

CURRENT MEDICATIONS- list all medications you currently take including vitamins, supplements, and over the counter

Medication	Dose	Times Daily

DO YOU OR HAVE YOU EVER HAD?

☐ Heart Condition ☐ High Blood Pressure
☐ Stroke ☐ Diabetes
☐ Asthma ☐ Lung Problems/COPD
☐ Arthritis ☐ Seizure disorder
☐ Hyperthyroid ☐ Cancer
☐ Hypothyroidism Type? ____________
☐ Depression/Anxiety ☐ Sleep Apnea
☐ AIDS/HIV ☐ Anemia/Blood Disorder
☐ Colitis/Crohns ☐ M S
☐ Rheumatoid Arthritis ☐ Kidney disease
☐ Gallbladder Issues ☐ Jaundice
☐ Hepatitis ☐ Urinary Issues

☐ Radiation – body part?__________when________
☐ Chemotherapy- type __________when________
☐ COVID Vaccine - when? ____________
☐ Last Flu Vaccine- when? ____________
☐ Pneumonia Vaccine-when? ____________
☐ Last Colonoscopy- when? ____________
☐ Last Mammogram-when? ____________

HAVE YOU EVER HAD SURGERY?

Type	Month/Year

Do you have any other chronic medical conditions not listed above? ______________________________

____

____

GYNECOLOGIC HISTORY

Menstrual/Gynecologic History

Age at First Menstrual Period ________ Date of Last Period ____________ Age at Menopause ________
Do you now use birth control? ☐ No ☐ Yes- type? ______________how long? ____________
Have you ever taken hormone replacements? ☐ No ☐ Yes- how long? ____________
Have you ever had? ☐ Herpes ☐ HPV/Genital warts ☐ Chlamydia ☐ Pelvic Inflammatory Disease
Are you currently sexually active? ☐ Yes ☐ No

Obstetrical History

Have you ever been pregnant? ☐ No ☐ Yes How many times? ________
Number of vaginal deliveries: ______ C-Section:_______ Termination: __________Miscarriage: _______

Women's Cancer Care Associates, LLC Initial Patient History and Physical

Patient Name: ____________________

REVIEW OF SYSTEMS

Are you ***currently*** experiencing any of the following?

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats

Eyes
- ☐ No problems or concerns
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Vision loss
- ☐ Other: ____________

Ear, Nose, Mouth, Throat
- ☐ No problems or concerns
- ☐ Hearing loss
- ☐ Dental problems
- ☐ Other: ____________

Cardiology
- ☐ No problems or concerns
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Pacemaker/defibrillator
- ☐ Irregular heartbeat
- ☐ Leg/ankle swelling
- ☐ Other: ____________

Respiratory
- ☐ No problems or concerns
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Cough
- ☐ Other: ____________

Gastrointestinal
- ☐ No problems or concerns
- ☐ Loss of appetite
- ☐ Heartburn or indigestion
- ☐ Abdominal pain or discomfort
- ☐ Recurrent diarrhea
- ☐ Recurrent constipation
- ☐ Bloody stool
- ☐ Other: ____________

Genitourinary
- ☐ No problems or concerns
- ☐ Difficult or painful urination
- ☐ Frequent urination
- ☐ Recurrent bladder infection
- ☐ Vaginal itching
- ☐ Vaginal discharge
- ☐ Irregular periods
- ☐ Painful periods/cramping
- ☐ Heavy periods
- ☐ Sexual problems
- ☐ Lump or sore on vulva
- ☐ Other: ____________

Musculoskeletal
- ☐ No problems or concerns
- ☐ Difficulty walking
- ☐ Joint aches or stiffness
- ☐ Backache/pain
- ☐ Other: ____________

Breast
- ☐ No problems or concerns
- ☐ Lump in breast
- ☐ Pain in breast
- ☐ Change in breast size
- ☐ Other: ____________

Skin
- ☐ No problems or concerns
- ☐ Sores
- ☐ Rashes
- ☐ Moles
- ☐ Other: ____________

Neurologic
- ☐ No problems or concerns
- ☐ Difficulty concentrating
- ☐ Frequent headaches
- ☐ Dizziness/fainting
- ☐ Numbness in hands
- ☐ Numbness in feet
- ☐ Seizures/convulsions
- ☐ Other: ____________

Psychosocial
- ☐ No problems or concerns
- ☐ Nightmares
- ☐ Anxious/nervous
- ☐ Trouble sleeping
- ☐ Lonely/depressed
- ☐ Work/family issues
- ☐ Other: ____________

Hematologic/Lymphatic
- ☐ No problems or concerns
- ☐ Easy bleeding or bruising
- ☐ Anemia or other blood issues
- ☐ Frequent infections
- ☐ Swelling of glands
- ☐ Other: ____________

PLEASE SIGN

I authorize Women's Cancer Care Associates, LLC to use and disclose my protected health information as reasonably necessary for treatment, payment, and health care operations.

X ______________________________ ____________________

Patient's Signature Date