

Chattanooga Surgical Oncology
& Associates, PLLC

Name: _____
Date of birth: _____ Age: _____
Office Visit Date: _____

PATIENT HISTORY

Dr. who sent you to this Office:	Primary Care Doctor:	Other Doctors you are seeing

Chief Complaint: (Reason for your visit) _____

History of Present Illness or Injury

Is this illness/ injury employment related? Yes No

Please answer all questions. If one does not apply to you, please write N/A (not applicable).

- **Location:** _____
(Where on the body does the symptom occur)
- **Modifying Factors:** _____
(Things that make symptoms better or worse)
- **Pain Severity:** _____
pain scale 1-10 1 being minimal and 10 being severe
- **Duration:** _____
(How long have you had symptom/pain? How long does it last?)
- **Timing:** _____
(When symptoms occur . . . after meals or exercise, etc.)
- **Quality:** _____
(Character of symptoms/pain . . burning, gnawing, stabbing, etc.)

Past Medical History (Personal): Please circle Yes if you have any of the following medical problems and please **answer the questions regarding the problem.** Circle No if you do not have the problem.

High Blood Pressure	Yes No	Diabetes	Yes No	Respiratory Problems	Yes No
		on Insulin	Yes No	<input type="checkbox"/> COPD <input type="checkbox"/> Asthma	
Heart Trouble	Yes No	Stroke/TIA (mini stroke)	Yes No	<input type="checkbox"/> _____	
Explain _____					
Angina/Chest Pain	Yes No	Hepatitis	Yes No	Bleeding Problems	Yes No
How Often? _____ <input type="checkbox"/> on exertion <input type="checkbox"/> at rest		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C		Explain: _____	
Heart Attack	Yes No	HIV/AIDS	Yes No	Cancer	Yes No
Date of attack _____				Yr. Diagnosed _____	
		Blood clots/DVT	Yes No	Site of cancer _____	
		<input type="checkbox"/> Leg <input type="checkbox"/> Arm <input type="checkbox"/> Lung		Chemotherapy	Yes No
Other Medical Problems: _____				Radiation Therapy	Yes No

Drug Allergies: _____

List all Surgeries:

Type of Surgery	Date of Surgery	Dr. who performed surgery

Family Medical History: Please circle Yes, No, or Unknown as appropriate for parents, grandparents, siblings and children.
If yes, please list relation to patient

Cancer-Type/Location	Yes	No	Unknown
Diabetes	Yes	No	Unknown
Heart Disease	Yes	No	Unknown
Stroke	Yes	No	Unknown
Bleeding Disorder	Yes	No	Unknown
Other:	Yes	No	Unknown

Social History:

Marital Status: Married Single Separated Divorced Widowed

Tobacco Use: Never

If used tobacco then: current user former user
cigarettes/cigars/dip/snuff yrs used _____ packs/cigars per day _____ pouch/cans per day _____

Alcohol Use: Never

If used alcohol/beer then: current user former user
Years used _____ Amount _____ Frequency _____

Drug Use: Never

If drug use then: current user former user
Years used _____ Type _____

Occupation: _____ Years at listed occupation _____
 Employed Retired Other _____

Review of Systems:

General

- none
- fever/chills/sweats
- fatigue
- weight gain
- weight loss
- pain: location _____
- level (0-10) _____
- other: _____

Gastrointestinal/Nutrition

- none
- yellow skin or eyes
- nausea/vomiting
- problems swallowing
- reflux/indigestion
- blood in stools
- black/tarry stools
- diarrhea
- constipation
- other: _____

Breast

- none
- breast mass or lump
- bloody nipple discharge
- breast pain
- age at first menstrual period _____
- age at first pregnancy _____
- breast fed infant: yes no n/a
- age at menopause _____
- other: _____

Cardiovascular

- none
- Chest pain
- Palpitations
- Swelling hands/feet
- Other: _____

Hematologic/Lymphatic

- none
- easy bruising
- abnormal bleeding
- swelling in groin/armpit/neck
- other: _____

Skin

- none
- change in mole
- rash
- open sore
- other: _____

Neurological

- none
- frequent headaches
- paralysis or tremors
- convulsions/seizures
- numbness/tingling
- other: _____

Respiratory

- none
- shortness of breath
- cough
- wheezing/asthma
- bloody sputum
- other: _____

Genitourinary

- none
- blood in urine
- stool in urine
- kidney stones
- unable to control bladder
- other: _____

Musculoskeletal

- none
- joint pain or swelling
- back pain
- other: _____

Date of Last Colonoscopy: _____

Date of last Mammogram: _____

Patient Statement

To the best of my knowledge, the above information is accurate and complete.

Signed: _____ Date _____

Physician Statement

I have reviewed the questionnaire with the patient. Comments: _____

Signed _____ Date _____ Time _____