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| RCCA_logo_2  PATIENT MEDICAL HISTORY FORM |

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| Patient Name: |  | Date: |  |

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| Reason for this Visit: |  |
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Medical History: (Check the items that apply to you, currently or in the past)

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| 🞏 | None | 🞏 | Chronic Lung (COPD) |
| 🞏 | Anemia | 🞏 | Pneumonia / Bronchitis |
| 🞏 | Bleeding Problem | 🞏 | Sleep Apnea |
| 🞏 | Blood Clots | 🞏 | Stomach Ulcers |
| 🞏 | HIV / AIDS | 🞏 | Liver Disease |
| 🞏 | Diabetes | 🞏 | Pancreatitis |
| 🞏 | Thyroid Disease | 🞏 | Kidney Disease / Failure |
| 🞏 | High Blood Pressure | 🞏 | Arthritis |
| 🞏 | High Cholesterol | 🞏 | Osteoporosis |
| 🞏 | Heart Disease | 🞏 | Stroke |
| 🞏 | Heartburn / Reflux | 🞏 | Cancer |
| 🞏 | Irregular Heart Beat | 🞏 | Leukemia |
| 🞏 | Asthma | 🞏 | Lymphoma |
| 🞏 | Anxiety / Depression |  |  |

Other Medical History not listed above:

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Have you ever experienced:

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| 🞏 | Weight Loss – how much \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞏 | Fevers |
| 🞏 | Chills |
| 🞏 | Night Sweats |
| 🞏 | Fatigue |

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| Patient Name: |  |  |  |

**Social History**

Tobacco User:

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| 🞏 | Never Smoked | |  |  | | | | |  | |  |  | |  | |  | | |
| 🞏 | Quit Smoking When did you quit? | |  | | | | How many years did you smoke? | | | | | |  | | Yr(s) | |
| 🞏 | Currently smoke: | What age did you start? | | |  | How many packs? | |  | | /day | | | | | | | |

Alcohol User: Present or Past

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| 🞏 | Non-Drinker | | |  | | | |
| 🞏 | Drinker | \_\_\_\_\_ | Current | | \_\_\_\_\_ | Past | How many drinks per day? | | \_\_\_\_\_ |

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| Are you: |  | | | Employed | | | | | |  | Unemployed | | |  | | Retired | |  | Disabled | | | | |
| (Former) Occupation: | | | | |  | | | | | | | | | | | | | | | | | |
| Marital Status: | |  | Married | | |  | Single |  | Widowed | | |  | Divorced | |  | | Domestic Partner | | | |
|  | |  | Lives alone | | | | |  | Lives with family | | | | | |  | |  | | |
| Children | |  | Yes | | |  | No | | | | | | | | | | | | | | |

Health Maintenance:

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| Sigmoidoscopy / Colonoscopy: |  | Yes |  | No | Date: |  |
| Bone Density: |  | Yes |  | No | Date: |  |
| Influenza (Flu) Shot |  | Yes |  | No | Date: |  |
| Pneumococcal Shot: |  | Yes |  | No | Date: |  |

Health Maintenance: **(Women Only)** Please list the date of:

Age of onset of period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever had a D&C? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take oral contraceptives? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age of menopause \_\_\_\_\_\_\_\_\_

If yes, what age did you start? \_\_\_\_\_\_\_\_ Do you take hormone replacement therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, at what age did you start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of live born children \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of you last mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How old were you when you had your first birth? \_\_\_\_\_\_\_ Date of your last pelvic exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of miscarriages \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of your last pap smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had abnormal vaginal bleeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you currently on hormone replacement therapy? \_\_\_\_\_\_\_\_\_\_

If yes, what hormonal therapy are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on any fertility drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, what fertility medications are taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Patient Name: |  |  |  |

Please list all surgeries you have had with approximate date:

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Family Medical History: Indicate any family members with cancer, blood disease or other disease

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|  | Age at Diagnosis |  | Disease |  | If deceased, cause of death |
| Father |  |  |  |  |  |
| Mother |  |  |  |  |  |
| Siblings |  |  |  |  |  |
| Siblings |  |  |  |  |  |
| Other |  |  |  |  |  |
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Drug Allergies (List all medication allergies):

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| Pharmacy / address / phone#: |  |
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| Patient Name: |  |  |  |

List all medications (including non-prescription) that you are currently taking:

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| Medication |  | Dose |  | Frequency |
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