



**LASKA ONCOLOGY
and HEMATOLOGY, LLC**
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Today's Date _____
Patient Name _____

MEDICAL HISTORY

1) What is your main reason for coming here? _____

Where and when was this diagnosed? _____

Please select anything that you may need help with below:

Housing in Anchorage: Yes No Finances: Yes No Care at Home: Yes No

Medical Equipment: Yes No Transportation: Yes No Emotional Support: Yes No

Other (please explain) _____

2) How would you describe your past health? Well Often Ill Almost Always Ill

List all previous doctors/physicians you have seen, including first name, city, state and phone:

Doctor/Physician	City/State	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3) Allergies to food or drugs:

Food or Drug	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

4) Medicines used regularly:

Medication Name	Dosage	used For
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5) Please list any previous cancer treatments, including radiation therapy

6) List all other surgeries. Include date, reason and doctor



7) Please list any problem(s) you may have had:

- | | | | |
|--|--|--|---|
| <input type="radio"/> Heart attack | <input type="radio"/> Arthritis | <input type="radio"/> Difficulty urinating | <input type="radio"/> Circulation problems |
| <input type="radio"/> Seizures/Epilepsy | <input type="radio"/> Ulcer | <input type="radio"/> Kidney problems | <input type="radio"/> Hepatitis/Jaundice at birth |
| <input type="radio"/> Gall bladder disease | <input type="radio"/> Change in bowel habits | <input type="radio"/> Mental health problems | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Liver disease | <input type="radio"/> Cancer | <input type="radio"/> Other lung disease | <input type="radio"/> Pneumonia |
| <input type="radio"/> Stroke | <input type="radio"/> Diabetes | <input type="radio"/> Chronic bronchitis/Emphysema | <input type="radio"/> High blood pressure |
| <input type="radio"/> Transfusion | <input type="radio"/> Other _____ | | |

8) For Women – Menstrual History

Age period began: ____ Cycle: ____ days Is your cycle regular at this time? Yes No Age at menopause: _____
Any abnormal discharge or bleeding? Yes No Birth Control of other hormones? Yes No
How many children? ____ How many pregnancies? ____ Age at first term delivery: _____
Still Births ____ Abortions _____ Did you breast-feed? Yes No

9) Social History:

Birthplace: _____ Do you live alone? Yes No
Marital Status: _____ Name of Spouse: _____
Do you have children? Yes No Ages of Children: _____
Occupation: _____ Unemployed? Yes No Retired? Yes No
Have you had any of the following in the last 2 years?
Change of Job? Yes No Previous occupation: _____
Change of residence? Yes No Environmental exposures? Yes No Loss of spouse, relative or friend? Yes No
Do you have interests or hobbies that you pursue with any regularity? Yes No
If yes, what? _____

Have you traveled outside the country? Yes No If yes, approximate dates: _____

10) Have you ever used tobacco? Yes No

Type: Cigar Cigarette Pipe Snuff Chewing Tobacco How much? _____ How often? _____
Have you quit? Yes No If yes, when did you quit? _____ Why did you quit? _____

11) Have you ever used Alcohol? Yes No

Are you currently using alcohol? Yes No What kind (beer, wine, hard liquor?) _____
How much? _____ How often? _____

12) Do you use recreational drugs of any kind? Yes No

What kind? _____ How much? _____ How often? _____



SYSTEMS REVIEW & FAMILY HISTORY

13) Are you currently experiencing any of the following? (please check any that apply)

- Pain Difficulty breathing Nausea or vomiting Change in vision Change in bowel or bladder habits
 Headaches Stress symptoms Weakness or numbness in arms or legs Depression or mood swings Forgetfulness or difficulty concentrating

Has your weight changed recently? Yes No Why? _____

Usual Weight _____ Current Weight _____ Do you exercise regularly? Yes No

Are you on a special diet? Yes No No Type: _____

Do you have pets? Yes No Type of pet(s): _____

14) Circle or underline all that apply in the chart below:

Health Problem	Comment (If yes, explain)
Are you having any vision problems?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you experiencing any sinus infections or nose bleeds?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you experiencing headaches or dizziness	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any difficulty swallowing?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you experiencing forgetfulness or difficulty concentrating?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any breast changes?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you having any difficult breathing?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any bowel changes?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you experiencing any bladder changes?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you experiencing any fevers or night sweats?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you any lymph node enlargement?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any skin conditions such as scaling, bruising, loss of skin or hair color or nail changes?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Are you experiencing any specific aches, pains or tenderness?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any muscular or neurological disorders?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you experiencing any sensory changes, ex. numbness, weakness, tingling of face or extremities?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Have you or are you currently experiencing depression, attempted suicide, mood swings or eating disorders?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Do you have any sexually transmitted diseases?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any congenital diseases or birth defects?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you experiencing nausea or vomiting?	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No

Additional comments:



15) Please complete your family history in the chart below:

Family Member	Alive?	Age / Age at death	List any health problems
Paternal Grandfather	<input type="radio"/> Yes <input type="radio"/> No		
Paternal Grandmother	<input type="radio"/> Yes <input type="radio"/> No		
Maternal Grandfather	<input type="radio"/> Yes <input type="radio"/> No		
Maternal Grandmother	<input type="radio"/> Yes <input type="radio"/> No		
Father	<input type="radio"/> Yes <input type="radio"/> No		
Mother	<input type="radio"/> Yes <input type="radio"/> No		
Sibling	<input type="radio"/> Yes <input type="radio"/> No		
Sibling	<input type="radio"/> Yes <input type="radio"/> No		
Sibling	<input type="radio"/> Yes <input type="radio"/> No		
Sibling	<input type="radio"/> Yes <input type="radio"/> No		
Sibling	<input type="radio"/> Yes <input type="radio"/> No		

For Nurse's Use

B/P _____ Pulse _____ HT _____ Wt _____ BSA _____