CANCER CARE OF NORTH FLORIDA, PA
289 SW STONEGATE TERRACE, SUITE 103
LAKE CITY, FL 32055

PATIENT INFORMATION AND MEDICAL HISTORY

PERSONAL:

Name_____ Date of Birth_____
Address_____
City, state_____ Zip Code_____
Social Security #_____ Marital status_____ Race_____
Home Phone (___)_____ Work Phone(___)_____
Cell Phone (___)_____ Spouses Name_____
In the event of emergency, notify _____
Phone Number(___)_____(different than home number)

MEDICAL INSURANCE:

PRIMARY: ____Medicare ____Medicaid ____Other:_____
Policy #:_____ Group #:_____
Name of policy holder: _____ DOB: _____
SECONDARY:_____
Policy #:_____ Group #:_____
Name of policy holder: _____ DOB: _____

CHIEF COMPLAINT:

What is the reason for today's visit? _____

MEDICAL HISTORY:

What doctor referred you to our facility? _____
Any allergies to foods or medications? _____
Any chronic illnesses such as Diabetes, high blood pressure, COPD, congestive heart failure? _____
Who are your main/primary doctors? _____
What drug store/pharmacy do you prefer? _____
Any past operations and year performed:

_____ _____
_____ _____

FAMILY HSITORY:
Has anyone in your family had?
Cancer or tumor_____ High blood pressure_____
Heart disease_____ Strokes_____
Diabetes_____ Kidney trouble_____

PERSONAL HSITORY:
Do you drink alcoholic beverages? ___Yes ___No How often_____ How long____
Do you use cigarettes? ___Yes ___ No Cigars? ___Yes ___No
Did you smoke previously? _____ When did you quit? _____
Do you use chewing tobacco or snuff? _____ How long_____
Do you live alone? _____ Do you have a caregiver? _____ Name_____
Current occupation_____ How long_____

CURRENT MEDICATIONS: include herbs, supplements, and vitamins

NAME	DOSE	PRESCRIBING MD

REVIEW OF SYSTEMS:

If you have had any of these, please circle and explain:

Head /neck
Skin problems
Headaches
Eye problems
Infections
Dental problems
Hoarseness
Thyroid problems

Cardiovascular/Respiratory
High cholesterol
High blood pressure
Chest pain or tightness
Coughing up blood
Heart palpitations
Shortness of breath w/ exertion
Shortness of breath at night or rest
Previous heart attacks
Previous stroke
Tuberculosis

Male
Prostate trouble

Muscle /Joints
Arthritis
Muscle cramps

Central nervous system
Epilepsy
Dizziness

Kidney/Bladder
kidney stones
urinary tract infections
frequent urination
difficulty starting a stream
urinate ____times a night
blood in urine

Digestive
indigestion or heartburn
difficulty swallowing
poor appetite
diarrhea/constipation
bloating
nausea/vomiting
stomach ulcers
hernia / gallbladder trouble
weight loss _____lbs.
jaundice / Hepatitis / hemorrhoids

Female
Have you gone through the change of life/
menopause LMP_____
vaginal discharge / breast lumps
Hormones / birth control pills

Blood
swollen glands / easy bruising
anemia / abnormal bleeding
Low or high white blood cell count
Low or high platelet count

Reviewed by:_____MD Date_____