CANCER TREATMENT AND WELLNESS CENTER
HISTORY SUMMARY SHEET

Today’s Date: ______________________

MEDICATIONS:
Include Prescriptions, ______________________________
Over the counter, and ______________________________
Herbal Medications ______________________________________

ALLERGIES: ______________________________________

PREVIOUS OPERATIONS: Please list year & hospital:
Eye Surgery __________________________________________
Tonsillectomy _________________________________________
Thyroid Surgery _______________________________________
Lung Surgery _________________________________________
Heart Surgery _________________________________________
Gallbladder Surgery ___________________________________
Hysterectomy _________________________________________
D&C __________________________________________________
Appendectomy _________________________________________
Hernia Surgery _________________________________________
Bladder Surgery _______________________________________
Prostate Surgery ______________________________________
Spinal Surgery _________________________________________
Other _________________________________________________

HAVE YOU BROKEN ANY BONES? If yes, please list:
Which Bone? __________________ Date: __________________
Which Bone? __________________ Date: __________________
Which Bone? __________________ Date: __________________

HAVE YOU EVER HAD RADIATION THERAPY? Yes _____ No _____
When? __________________________ Where? __________________________
Radiation Oncologist’s Name: _______________________________________
What part(s) of the body were treated? ________________________________
How many treatments? ______________________________________________

HAVE YOU HAD HORMONE THERAPY OR CHEMOTHERAPY? Yes ___ No ___
Medication: __________________________ Date: ________________
Medication: __________________________ Date: ________________
Medication: __________________________ Date: ________________
HAVE YOU HAD ANY OF THE FOLLOWING? If yes, please check:

_____ History of Cancer     _____ Decreased Appetite
_____ Fever      _____ Constipation
_____ Fatigue      _____ Diarrhea
_____ Weight Loss     _____ Blood in Stool
_____ Pain, where? _____________   _____ Hemorrhoids
_____ Headaches     _____ Laxative Use
_____ Vision Problems      _____ Hernias
_____ Hearing Problems     _____ Abdominal Pain
_____ Sinus Problems     _____ Frequent Urination
_____ Thyroid Disease     _____ Slow Urination
_____ Sore Throat     _____ Pain or Burning
_____ Hoarseness     _____ Blood in Urine
_____ Cough     _____ Kidney Stones
_____ Blood in Sputum     _____ Incontinence
_____ Emphysema     _____ Erectile Dysfunction
_____ Chronic Bronchitis     _____ Leg Swelling
_____ Asthma     _____ History of Blood Clots
_____ Positive TB Test     _____ Neurological Disorders
_____ Heart Attack     _____ Weakness in Limbs
_____ High Blood Pressure     _____ Paralysis
_____ Shortness of Breath     _____ Stroke
_____ Chest Pain     _____ Seizures
_____ Pacemaker     _____ Arthritis
_____ Reflux     _____ Gout
_____ Nausea     _____ Diabetes
_____ Vomiting     _____ Anemia
_____ Other ________________________________

FEMALES: Please complete the following information:

Could you be pregnant now?  Yes ______ No ______
Age of First Period: ___________
Number of Pregnancies: _______  Number of Deliveries: ______
Did you breastfeed?  Yes______ No ______
Are you still having periods?  Yes ____ No ____  Date of Last Period: ___________
Did you ever take birth control pills? Yes _____ No ______
Did you ever take hormone replacement? Yes _____ No ______
**FAMILY HISTORY:**

**Parents:**
- Father: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____________________
- Mother: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____________________

**Siblings:**
- Brother/Sister: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____________________
- Brother/Sister: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____________________
- Brother/Sister: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____________________
- Brother/Sister: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____________________
- Brother/Sister: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____________________

**Children:**
- Son/ Daughter: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____________________
- Son/ Daughter: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____________________
- Son/ Daughter: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____________________
- Son/ Daughter: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____________________
- Son/ Daughter: Living? _____ Age: _____ History of Cancer? Yes ____ No ____ Type _____________________

**Grandchildren:**
- Yes: _____ No _____ Any medical problems? _______________________________________

Is there any other family history of cancer? Please describe: ____________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

**SOCIAL HISTORY:**
- Where were you born? __________________________________
- Where have you lived most of your life? __________________________________________________________

Have you ever smoked? Cigarettes ______ Pipe ______ Cigar ______
If yes, how much per day? _______________________________________________________________________
For how many years? ___________________________________________________________________________
Have you quit? _________________ If yes, when?  ___________________________________________________

Do you drink alcohol? __________ If yes, how much? ________ How often? ______
Do you drink coffee/tea? _________ If yes, how much? ________ How often? ______

**WORK/EDUCATION HISTORY:**
- What is your occupation? __________________________________
- Are you still working? ________________________________
- Have you been exposed to asbestos or any other occupational chemicals or fumes? _________
  If yes please describe __________________________________
- What is your highest level of education? (Please check one)
  Elementary ______         High School ______     College ________   Some college _____ Graduate School ______
- Did you ever serve in the military? _________ For how long? _____________

**MARRITAL STATUS:**
- Are you? (check one ) _____ Single _____ Married _____ Divorced _____ Widowed
- Spouse’s name ________________________________________________
- Address: __________________________________________________________
- Phone Number: ____________________________________________________
PLEASE LIST THE NAMES AND LOCATIONS OF YOUR PHYSICIANS:

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DIETARY HISTORY:

Usual number of meals per day ______ Had this changed recently? __________________

Do you follow a special diet? ______ If yes, please explain ______________________________

Do you feel full after eating very little?  Yes ___ No ______

What is your usual weight? ______ What is your current height and weight? __________________

Your weight 6 months ago? ______ 1 year ago? ______

Any change in the past 6 weeks? ______ If yes, has it? Increased _____ or Decreased _____

What is your current level of intake? Any food _____ Some solid food _____ Liquids only _____

Is your ability to eat limited by any of the following (please check ALL that apply)

- Nausea ______
- Dry Mouth ______
- Aversion to odors ______
- Vomiting ______
- Mouth Sores ______
- Pain ______ where? ______________________
- No appetite ______
- Taste Change ______

Form completed by: ___________________________ Date: _____________

Signature

Form reviewed by: ___________________________ Date: _____________

Signature and Title