# CENTER FOR HEALTH AND CANCER PREVENTION H&P rev 062016

**Personal History** ***Please do not reformat or modify this form***

**USE BLACK INK**

Name (L, F) _____, _____
Age_____ D.O.B. ___/___/____ Today's Date_____/_____/_____
Appointment date _____/_____/_____
Who referred you _____ ____
Primary Care MD _____
Date of your appointment ___/____/____
Your Occupation _____
Employer _____
Marital Status □ M □ S □ D □W
Spouse's Occupation_____
Number of children ____ ages _____
Do you smoke? □ Yes □ No _____packs/day
Alcohol Intake □ wine □ liquor □ beer □ glasses
or _____ □ oz. / □ day □ week □ month
Height _____ft._____ in Weight_____

**Medical History** (*Please Complete All Questions)*

Reason you were referred _____
_____

□ yes □ no Take **prophylactic antibiotics** for an artificial joint, joint replacement, artificial/leaky heart valve, vascular graft, history of rheumatic fever? Explain _____
□ yes □ no □ N.A. **Abnormal Menses** Date of last period _____
□ yes □ no □ N.A. Could be **pregnant**?

□ yes □ no **Allergy** to any medications/anesthetics?
**LIST:** _____
□ yes □ no **Family history** of □ **colon cancer** or □ **colon polyps**
Please explain who, age of onset _____ ____
_____
□ yes □ no **Family or personal history** of □ breast □ uterine
□ prostate □ stomach □ esophageal **cancer**
who/age of onset _____

System Review

Do you have, or have you ever had, any of the following?

□ yes □ no rectal **bleeding** _____
□ Yes □ no **change** in bowel habits _____
□ yes □ no **constipation** _____
□ yes □ no chronic **diarrhea** _____
□ yes □ no rectal **pain** _____
□ yes □ no persistent **abdominal pain** _____
□ yes □ no persistent **heartburn** or indigestion _____
□ yes □ no **problem swallowing** _____
□ yes □ no frequent **use of antacids** or acid blockers
□ yes □ no colorectal **polyps** □ colorectal cancer
□ yes □ no **anemia** explain _____
□ yes □ no positive Hemoccult © test (**blood in stool**)
□ yes □ no **Prior colonoscopy** done? Date(s) _____
results _____
□ yes □ no **Prior** □ **sigmoidoscopy** or □ **barium enema** date_____
results _____
□ yes □ no **shortness of breath**
□ yes □ no **chest pain**, angina, heart problems
□ yes □ no □ **bleeding tendencies** □ **take blood thinners**
□ yes □ no **kidney problems**/kidney **failure**
□ yes □ no **liver problems**/hepatitis
□ yes □ no **sleep apnea**/use a CPAP machine
□ yes □ no □ N.A. **prostate symptoms:** □ hesitancy □ slow stream
□ night time awakening □ blood in urine □ high PSA □ enlargement

**Hospitalizations/Surgery**

| Dates | Diagnosis/Procedure Done | M.D. |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Medical Problems/Physicians you see regularly**

| Problem: | M.D. |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Medications**: *Please list **names** of all medications taken including **dose** and **frequency**. Please include all over-the-counter.*

| | Name | Dose | How Often |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

Rate Your Overall **Stress** Level (1-10, 10 highest) ___/10
What do you find **most stressful**? _____
**Interests**/Hobbies_____
Do you have any **other health concerns**? _____

*M.D. Use Only*

**Pt Initials:** _____ **Date:** ___/___/_____

***M.D. ONLY:*** ____ ***all records reviewed*** ___/___/ ***2017***