ESTABLISHED PATIENT UPDATE

NTGO
an Oncology Medical Home

PATIENT NAME _____ **DATE OF BIRTH** _____

TODAY'S DATE_____

PAST MEDICAL HISTORY — *Indicate any of the following that apply*

☐ Underactive Thyroid (Hypothyroidism)	☐ High Cholesterol (Hyperlipidemia)	☐ Diabetes	☐ Coronary Artery Disease
☐ Heart Attack	☐ Peripheral Vascular Disease	☐ Congestive Heart Failure	☐ Atrial Fibrillation
☐ Deep Vein Thrombosis	☐ Pulmonary Embolism	☐ High Blood Pressure (Hypertension)	☐ COPD
☐ Asthma	☐ Osteoporosis	☐ Lumbar Disk Disease	☐ Frequent Urinary Infections
☐ Renal Failure ☐ Dialysis	☐ Kidney Stones	☐ Upper or Lower GI Bleed	☐ Fibrocystic Breast Disease
☐ Ulcerative Colitis	☐ Crohn's Disease	☐ Irritable Bowel Syndrome	☐ Cirrhosis
☐ Hepatitis	☐ Seizure Disorder	☐ CVA (Stroke)	☐ TIA (Transient Ischemic Attack)
☐ Peripheral Neuropathy	☐ Depression	☐ Schizophrenia	☐ Bipolar Disorder
☐ Rheumatoid Arthritis	☐ Auto Immune Disorder(s) _____		☐ HIV / AIDS
☐ HPV	☐ Herpes	☐ Gonorrhea / Chlamydia	☐ Syphilis

GENETIC TESTING? Have you or a family member ever had Genetic Testing? ☐ Yes ☐ No

If yes, please complete type of test: BRCA ___Positive ___Negative

Lynch Syndrome ___Positive ___Negative

PAST SURGICAL HISTORY — *Indicate any of the following surgeries that apply*

☐ Tonsillectomy	☐ Adenoidectomy	☐ Cataract Surgery	☐ Thyroidectomy
☐ Cervical Disk Fusion	☐ Pacemaker Insertion	☐ Coronary Bypass Stenting	☐ Coronary Artery Bypass Graft
☐ Exploratory Laparotomy	☐ Exploratory Laparoscopy	☐ Appendectomy	☐ Gallbladder Removal (Cholecystectomy)
☐ Removal Spleen (Splenectomy)	☐ Stomach Removal (Partial Gastrectomy)	☐ Surgery for Aneurysm (Aneurysmectomy)	☐ Femoro-Popliteal Bypass
☐ Varicose Vein Stripping	☐ Inguinal Hernia Repair (Inguinal Herniorraphy)	☐ Ventral Hernia Repair (Ventral Herniorraphy)	☐ Hemorrhoidectomy
☐ Hysterectomy – partial, ovaries were NOT removed (ovarian preservation)	☐ Hysterectomy – total, ovaries WERE removed (salpingo oophorectomy)	☐ C-Section	☐ Tubal Ligation (tubes tied)
☐ Organ Transplant	☐ Other:		

PAST CANCER HISTORY — *Indicate any of the following cancers that apply*

☐ Breast ☐ Cervix ☐ Ovarian ☐ Uterus ☐ Colon ☐ Lung ☐ None ☐ Other:

SOCIAL HISTORY

BLOOD TRANSFUSIONS If necessary, will you accept blood during surgery? ☐ Yes ☐ No

TOBACCO use ☐ Non-Smoker ☐ Current Every day smoker ☐ Current Some day smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Pipe smoker ☐ Chew Tobacco ☐ Moist powdered tobacco ☐ Snuff ☐ E-cigarettes ☐ Former smoker
☐ Previous (date stopped): _____ Number of years used? _____ # packs per day: _____

ALCOHOL use ☐ Never ☐ Occasionally ☐ Previous ☐ Current Number of years? _____
On average, how many drinks per: Day _____ Week _____ Type: ☐ Wine ☐ Beer ☐ Spirits

DRUG use *Do you use illicit drugs?* ☐ Yes ☐ No Type:_____

MARITAL Status ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

OCCUPATION ☐ Current_____ ☐ Secondary _____ ☐ Retired ☐ Unemployed

PATIENT NAME _____ **DATE** _____

FAMILY MEDICAL HISTORY

Mother ☐ Alive, age _____ ☐ Deceased at age _____, cause of death: _____

Father ☐ Alive, age _____ ☐ Deceased at age _____, cause of death: _____

Siblings *Number of:* Living Brothers: ____ Living Sisters: _____ Deceased Siblings: _____

FAMILY CANCER HISTORY

☐ None ☐ Unknown ☐ Breast ☐ Ovarian ☐ Lung ☐ Pancreatic ☐ Colon ☐ Prostate ☐ Thyroid ☐ Melanoma
☐ Neurofibromatosis ☐ Familia Adenomatous Polyposis (FAP) ☐ Endometrial ☐ Other:

FAMILY DISEASE HISTORY

☐ None ☐ Unknown ☐ High Blood Pressure (Hypertension) ☐ Diabetes ☐ Coronary Artery Disease
☐ High Cholesterol (Hyperlipidemia) ☐ Other:

HEALTH MAINTENANCE HISTORY

Colonoscopy ☐ Never ☐ Date of last: _____ with Dr._____ ☐ Scheduled for_____

Mammogram ☐ Never ☐ Date of last: _____ with Dr._____ ☐ Scheduled for_____

Pap Smear ☐ Never ☐ Date of last: _____ with Dr._____ ☐ Scheduled for_____

Most recent Flu vaccine (month/year) _____

Have you ever had a Pneumonia vaccine? ☐ NO ☐ YES (month/year) _____

Have you had the Gardasil vaccine series? ☐ NO ☐ YES (month/year) _____ _____ _____

DRUG ALLERGIES — *list any medication allergies below*

	Medication	Reaction
1.		
2.		
3.		

FOOD ALLERGIES — *list any food allergies below*

	Food	Reaction
1.		
2.		
3.		

PHARMACY — *Complete all information of your pharmacy*

Pharmacy Name	Address	Phone#
_____	_____	_____