nho Radiation Oncology

**8001 Eiger Drive, Lincoln, NE, 68516 | 3240 Folkways Boulevard, Lincoln, NE 68504 | 552 Sargent Street, Beatrice, NE 68310**

## PERSONAL HEALTH HISTORY

SSN _____

NAME_____
Last First Middle Initial

DOB _____/_____/_____ Height _____ Sex M / F Email _____

ADDRESS _____ CITY _____ STATE ____ ZIP_____

Home Phone ( ) _____ - _____ Cell Phone ( ) _____ - _____ **Okay to leave voicemail?** YES / NO

**RACE** (circle one) Alaskan Native/other Pacific Islander American Indian/Native American Asian

Black/African American Hispanic White Other Decline to Answer

**Please list your regular health care providers (Family Physicians, Internists, Gynecologists, Specialists, PAs, NPs):**

_____

**CURRENT MEDICATIONS** list any prescription, non-prescription & supplements or **provide a list** for photocopying

| Medication | Dose | Frequency/Time per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**ALLERGIES**:_____

## PAST MEDICAL HISTORY

| Previous Operations/Procedures | Surgeon | Location | Month/Year |
|---|---|---|---|
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**Do you currently have, or have you previously had, any of the following?** (Circle those that apply)

Asthma
Bleeding Problems
Blood Clots
Cancer (before current problem)
Cardiovascular Disease
COPD (chronic bronchitis or emphysema)
Diabetes
Gastroesophageal Reflux
Heart Attack
Heart Disease
High Cholesterol
Hypertension
Kidney Stones
Liver Problems
Pneumonia
Pacemaker/Defibrillator (Provide card)
Psychiatric Disorders
Seizure
Stroke
Thyroid Problems
Other _____

**Most recent Colonoscopy:** Date:_____ Location: _____

**Have you had a bilateral hip replacement?** **YES** **NO**

**Have you fallen within the last 30 days?** **YES** **NO**

**FEMALE PATIENTS ONLY**

Are you having regular menstrual cycles? YES NO Date of last menses: _____

Are you post-menopausal? YES NO

**Most recent Mammogram:** Date: _____ Location: _____

**SOCIAL HISTORY**

Marital Status (circle one): Married Divorced Single Widowed Other

Spouse or Significant Other's Name:_____

Please list other individuals who are involved in your health care: _____

_____

Occupation (current or prior): _____ Number of work hrs/wk:_____

**HABITS**

Tobacco use (circle one): Never Smoker Former Smoker Current Smoker Other (pipe/chew)

# of packs/day _____ Age started _____ Age quit _____ Other Drug Use: _____

Typical number of alcoholic drinks: _____ per day/week/month/year (circle one)

Environmental Exposures (Asbestos, Radiation, Inhaled dust, etc): _____

**FAMILY HISTORY** Please list any family (immediate blood relative) with a history of cancer

| Relation to you (maternal/paternal) | Cancer Type | Age when it developed |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Do you know any blood relative(s) who have had or currently has:** (give relationship)

Heart Disease_____ Stroke_____ High Blood Pressure_____

Diabetes_____ Epilepsy_____ Depression _____

Kidney Disease_____ Lung Disease _____ Other mental illness _____

Any other diseases that tend to run in the family? _____

**EMERGENCY CONTANT**

| Name of contact | Relation | Phone Number |
|---|---|---|
| | | |
| | | |