PLEASE PRINT YOUR NAME: _____

Mount Sinai

**The Derald H. Ruttenberg Treatment Center**
One Gustave L. Levy Place
New York, New York 10029

MRN -
V -

# HEMATOLOGY ONCOLOGY PERSONAL HISTORY FORM

Please provide us with the following information to the best of your ability. This information will assist in planning your treatment. Your oncology nurse will be able to answer any questions you may have.

Today's Date: ____/____/____ Name of Person Completing Form:_____

Relationship to the Patient: _____

What is the problem, which has brought you to the doctor's office today? _____

_____

***History of Present Illness:***

•What are your initial symptoms?_____

•When did these symptoms begin?_____

***History of Surgical Biopsies or Procedures Related to Your Present Illness***

| Type of Surgery | Date Performed | Name of Hospital or Office Where Performed | Name of Surgeon the Performed the Procedure/Biopsy |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Have you received any treatment for Cancer ☐ Yes ☐ No

| Name of Chemotherapy Drugs | Dates Given | Name of Hospital or Office | Name of the Medical Oncologist |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Have your received any Radiation Therapy Treatments? ☐ Yes ☐ No

| Dates of Treatment | Name of Hospital or Office Where You Received Your Treatments | Name of Radiation Oncologist |
|---|---|---|
| 1. | | |
| 2. | | |

***Family Medical History:***

•Please list any blood relatives who have had cancer.

| Relationship to You | Type of Cancer | Age of Onset | Relationship to You | Type of Cancer | Age of Onset |
|---|---|---|---|---|---|
| 1. | | | 3. | | |
| 2. | | | 4. | | |

•Please list other blood relatives with significant illness ( e.g. heart disease, diabetes, etc.)

_____

_____

***Social History:***

Marital Status: _____ # of Children: _____ # of Grandchildren: _____

Identify a significant support person(s): _____

Where do you reside: ☐ Apartment ☐ Private house ☐ Other _____

Ethnic background: ☐ Asian ☐ Black ☐ Filipino ☐ Hispanic ☐ Indian ☐ Native American
☐ Caucasian (white) ☐ Other _____

Education: _____ Occupation: _____

To your knowledge have your ever worked with hazardous chemical? ☐ Yes ☐ No

If Yes, please describe: _____

Present alcohol use: _____Less than 2 drinks per day _____More than 2 drinks per day
Past alcohol use: _____Less than 2 drinks per day _____More than 2 drinks per day

Dentures: ☐ Upper ☐ Lower

Nutrition: Are you currently on any special diet or do you have a nutritional concern? _____, if so, please describe: _____

_____

Allergies: Medications☐ No ☐ Yes, please list:_____

Foods (i.e., shellfish) ☐ No ☐ Yes, please list: _____

Have you ever had an adverse reaction during or following an x-ray examination with a dye? ☐ No ☐ Yes, describe:_____

_____

Please use this space to provide any information that you feel may assist us in providing your medical and nursing care: _____

_____

**Form reviewed by:**

| **Print Name & Title** | **Signature** | **Date& Time** | **Dict #** |
|---|---|---|---|
| | | | |

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DERALD H RUTTENBERG
TREATMENT CENTER
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***Physical Examination***

| Examination/Test | Yes | No | Date |
|---|---|---|---|
| Dental exam | | | |
| Rectal exam | | | |
| Stool test for blood | | | |
| Colonoscopy | | | |
| Prostate examination | | | |
| Breast examination | | | |
| Mammogram | | | |
| Chest x-ray | | | |
| Pap smear | | | |

***Medical History***: Please check appropriate column to indicate illness or symptom you may be currently experiencing or which has been a problem in the past.

| Illness/Symptom | Present | Past | Never | Illness/Symptom | Present | Past | Never |
|---|---|---|---|---|---|---|---|
| Asthma | | | | Enlarged prostate | | | |
| Emphysema | | | | Urinary infections | | | |
| Pneumonia | | | | Changes in hearing | | | |
| Tuberculosis | | | | Changes in vision | | | |
| Shortness pf breathe | | | | Headaches | | | |
| Coughing up blood | | | | Fainting | | | |
| Persistent cough | | | | Dizziness | | | |
| Chest pain | | | | Loss of balance | | | |
| Swollen ankles | | | | Seizures | | | |
| Heart disease | | | | Numbness or tingling extremities | | | |
| Angina | | | | Glaucoma | | | |
| Stroke | | | | Cataracts | | | |
| High blood pressure | | | | Diabetes | | | |
| Ulcer | | | | Excessive sweating | | | |
| Hiatus hernia | | | | Night sweats | | | |
| Constipation | | | | Fever or chills | | | |
| Diarrhea | | | | Anemia | | | |
| Blood in stool | | | | Bruising/bleeding | | | |
| Colitis/Crohn's | | | | Broken bones | | | |
| Hemorrhoids | | | | Gout | | | |
| Hernia | | | | Skin disorders | | | |

***Medical history Continued***: Please check appropriate column to indicate illness or symptom you may be currently experiencing or which has been a problem in the past.

| Illness/Symptom | Present | Past | Never | Illness/Symptom | Present | Past | Never |
|---|---|---|---|---|---|---|---|
| Change in appetite | | | | Thyroid disease | | | |
| Weight loss | | | | Sleeping /disorder | | | |
| Weight gain | | | | Impotence | | | |
| Psychiatric disorder | | | | Back pain | | | |
| Nausea or vomiting | | | | Other pain (specify: | | | |
| Persistent indigestion | | | | Prosthesis | | | |
| Blood in the urine | | | | Other: | | | |
| Difficulty urinating | | | | | | | |

For which illness and/or symptom(s) have you required:

•Hospitalization?_____

•Surgery?_____

•Medical Treatment?_____

***Medications:*** Please list all medications that you are currently taking including non-prescribed drug.

| Medication | Dose | Frequency | Reasons |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

**Form reviewed by:**

| **Print Name & Title** | **Signature** | **Date & Time** | **Dict #** |
|---|---|---|---|