

**Chattanooga Surgical Oncology**  
& Associates, PLLC

Name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Office Visit Date: \_\_\_\_\_

**PATIENT HISTORY**

|   |                             |                                     |
|---|-----------------------------|-------------------------------------|
| <b>Dr. who sent you to this Office:</b> | <b>Primary Care Doctor:</b> | <b>Other Doctors you are seeing</b> |
|   |                             |                                     |
|   |                             |                                     |

**Chief Complaint:** (Reason for your visit) \_\_\_\_\_

**History of Present Illness or Injury**

Is this illness/ injury employment related?  Yes  No

Please answer all questions. If one does not apply to you, please write N/A (not applicable).

- **Location:** \_\_\_\_\_  
(Where on the body does the symptom occur)
- **Modifying Factors:** \_\_\_\_\_  
(Things that make symptoms better or worse)
- **Pain Severity:** \_\_\_\_\_  
pain scale 1-10 1 being minimal and 10 being severe
- **Duration:** \_\_\_\_\_  
(How long have you had symptom/pain? How long does it last?)
- **Timing:** \_\_\_\_\_  
(When symptoms occur . . . after meals or exercise, etc.)
- **Quality:** \_\_\_\_\_  
(Character of symptoms/pain . . burning, gnawing, stabbing, etc.)

**Past Medical History (Personal):** Please circle Yes if you have any of the following medical problems and please answer the questions regarding the problem. Circle No if you do not have the problem.

|  |     |    |   |     |    |   |     |    |
|--|-----|----|---|-----|----|---|-----|----|
| <b>High Blood Pressure</b>   | Yes | No | <b>Diabetes</b>   | Yes | No | <b>Respiratory Problems</b>                                   | Yes | No |
|  |     |    | on Insulin  | Yes | No | <input type="checkbox"/> COPD <input type="checkbox"/> Asthma |     |    |
| <b>Heart Trouble</b>   | Yes | No | <b>Stroke/TIA (mini stroke)</b>   | Yes | No | <input type="checkbox"/> _____                                |     |    |
| Explain _____  |     |    |   |     |    | <b>Bleeding Problems</b>                                      | Yes | No |
| <b>Angina/Chest Pain</b>   | Yes | No | <b>Hepatitis</b>  | Yes | No | Explain: _____  |     |    |
| How Often? _____ <input type="checkbox"/> on exertion <input type="checkbox"/> at rest |     |    | <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C        |     |    | <b>Cancer</b>   | Yes | No |
| <b>Heart Attack</b>  | Yes | No | <b>HIV/AIDS</b>   | Yes | No | Yr. Diagnosed _____   |     |    |
| Date of attack _____   |     |    | <b>Blood clots/DVT</b>  | Yes | No | Site of cancer _____  |     |    |
|  |     |    | <input type="checkbox"/> Leg <input type="checkbox"/> Arm <input type="checkbox"/> Lung |     |    | Chemotherapy  | Yes | No |
| <b>Other Medical Problems:</b> _____   |     |    |   |     |    | Radiation Therapy   | Yes | No |

**Drug Allergies:** \_\_\_\_\_

**List all Surgeries:**

| Type of Surgery | Date of Surgery | Dr. who performed surgery |
|-----------------|-----------------|---------------------------|
|                 |                 |                           |
|                 |                 |                           |
|                 |                 |                           |
|                 |                 |                           |
|                 |                 |                           |

**Family Medical History:** Please circle Yes, No, or Unknown as appropriate for parents, grandparents, siblings and children.  
If yes, please list relation to patient

| Cancer-Type/Location | Yes | No | Unknown |  |
|----------------------|-----|----|---------|--|
| Diabetes             | Yes | No | Unknown |  |
| Heart Disease        | Yes | No | Unknown |  |
| Stroke               | Yes | No | Unknown |  |
| Bleeding Disorder    | Yes | No | Unknown |  |
| Other:               | Yes | No | Unknown |  |

**Social History:**

Marital Status:  Married  Single  Separated  Divorced  Widowed

Tobacco Use:  Never

If used tobacco then:  current user  former user  
cigarettes/cigars/dip/snuff yrs used \_\_\_\_\_ packs/cigars per day \_\_\_\_\_ pouch/cans per day \_\_\_\_\_

Alcohol Use:  Never

If used alcohol/beer then:  current user  former user  
Years used \_\_\_\_\_ Amount \_\_\_\_\_ Frequency \_\_\_\_\_

Drug Use:  Never

If drug use then:  current user  former user  
Years used \_\_\_\_\_ Type \_\_\_\_\_

Occupation: \_\_\_\_\_ Years at listed occupation \_\_\_\_\_  
 Employed  Retired  Other \_\_\_\_\_

**Review of Systems:**

**General**

- none
- fever/chills/sweats
- fatigue
- weight gain
- weight loss
- pain: location \_\_\_\_\_
- level (0-10) \_\_\_\_\_
- other: \_\_\_\_\_

**Gastrointestinal/Nutrition**

- none
- yellow skin or eyes
- nausea/vomiting
- problems swallowing
- reflux/indigestion
- blood in stools
- black/tarry stools
- diarrhea
- constipation
- other: \_\_\_\_\_

**Integumentary/ (Breast~Skin)**

- None
- Breast mass or lump
- Bloody nipple discharge L \_\_\_\_\_ R \_\_\_\_\_
- Breast pain L \_\_\_\_\_ R \_\_\_\_\_
- Change in mole: Location \_\_\_\_\_
- Rash: Location \_\_\_\_\_
- Open Sore: Location \_\_\_\_\_
- Other: \_\_\_\_\_

**Cardiovascular**

- none
- Chest pain
- Palpitations
- Swelling hands/feet
- Other: \_\_\_\_\_

**Hematologic/Lymphatic**

- none
- easy bruising
- abnormal bleeding
- swelling in groin/armpit/neck
- other: \_\_\_\_\_

**Psychiatric**

- No issues
- Depression
- Anxiety
- Other: \_\_\_\_\_

**Neurological**

- none
- frequent headaches
- paralysis or tremors
- convulsions/seizures
- numbness/tingling
- other: \_\_\_\_\_

**Respiratory**

- none
- shortness of breath
- cough
- wheezing/asthma
- bloody sputum
- other: \_\_\_\_\_

**Genitourinary**

- none
- blood in urine
- stool in urine
- kidney stones
- unable to control bladder
- other: \_\_\_\_\_

**Musculoskeletal**

- none
- joint pain or swelling
- back pain
- other: \_\_\_\_\_

Date of Last Colonoscopy: \_\_\_\_\_

Date of last Mammogram: \_\_\_\_\_

**Patient Statement**

To the best of my knowledge, the above information is accurate and complete.

Signed: \_\_\_\_\_ Date \_\_\_\_\_

**Physician Statement**

I have reviewed the questionnaire with the patient. Comments: \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_