Chattanooga Surgical Oncology
& Associates, PLLC

Name: _____
Date of birth: _____ Age: _____
Office Visit Date: _____

PATIENT HISTORY

Dr. who sent you to this Office:	Primary Care Doctor:	Other Doctors you are seeing

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.*

High Blood Pressure Yes No

Heart Trouble Yes No
Explain _____

Angina/Chest Pain Yes No
How Often? _____ ☐ on exertion ☐ at rest

Heart Attack Yes No
Date of attack _____

Diabetes Yes No
on Insulin Yes No

Stroke/TIA (mini stroke) Yes No

Hepatitis Yes No
☐ A ☐ B ☐ C

HIV/AIDS Yes No

Blood clots/DVT Yes No
☐ Leg ☐ Arm ☐ Lung

Respiratory Problems Yes No
☐ COPD ☐ Asthma
☐ _____

Bleeding Problems Yes No
Explain: _____

Cancer Yes No
Yr. Diagnosed _____
Site of cancer _____
Chemotherapy Yes No
Radiation Therapy Yes No

Other Medical Problems: _____

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** _____