

LAS VEGAS CANCER CENTER

PATIENT NAME _____ AGE _____

REFERRED BY _____

PAST HISTORY

CHILDHOOD DISEASES _____ HIGH BLOOD PRESSURE: Y N
RHEUMATIC FEVER: Y N DIABETES: Y N TUBERCULOSIS: Y N
HEART PROBLEMS _____

SURGERIES _____

ALLERGIES: Y N LIST: _____
HAVE YOU EVER TAKEN PENCILLIN? Y N HAVE YOU EVER TAKEN SULFA? Y N

FAMILY HISTORY

MOTHER: LIVING DEAD AGE _____ CAUSE OF DEATH _____
FATHER: LIVING DEAD AGE _____ CAUSE OF DEATH _____
BROTHERS: LIVING _____ AGE _____ DEAD _____ AGE _____
SISTERS: LIVING _____ AGE _____ DEAD _____ AGE _____

FAMILY MEMBERS WITH HISTORY OF CANCER, DIABETES, T.B., HEART DISEASE

SOCIAL HISTORY

MARRIED SINGLE DIVORCED WIDOWED
HOW'S YOUR HEALTH? EXCELLANT GOOD FAIR POOR
OCCUPATION _____ CURRENTLY WORKING Y N
SONS: _____ AGES _____
DAUGHTERS _____ AGES _____
SMOKE: Y N HOW MUCH? _____ DRINK ALCOHOL? Y N HOW MUCH? _____
MEDICATION CURRENTLY TAKING: _____

PHYSICAL ASSESSMENT

TEMP _____ PULSE _____ RESP _____ B/P _____ WT _____
LUNGS SOB _____ WHEEZE _____ COUGH _____ SPUTUM _____ HOW LONG? _____
CARDIO RHYTHM _____ CHEST PAIN _____ EDEMA _____
G.I. APPETITE _____ N/V/D _____ BOWEL HABITS _____
G.U. DYSURIA _____ FREQUENCY _____ HEMATURIA _____ URGENCY _____
MENOPAUSE Y N WT LOSS Y N PAIN Y N WHERE? _____ FATIGUE Y N

OTHER PERTINENT MEDICAL HISTORY

NURSE SIGNATURE _____

DATE _____