Name:

PATIENT SUMMARY

Patient Overview

Nickname	
Birthdate	
Gender	
Ethnicity/Race	
Preferred language	
Spoken languages	
Read languages	
Primary care physician	
Referring physician	

Employment

Employment Status		
Employer		
Employer Address		
Employer Phone		
Occupation 1		
Dates	From:	To:
Occupation 2		
Dates	From:	To:
Military service:	From:	To:

Spouse Information

Marital status	
Spouse	
Birthdate	
Employer	
Employer address	
Employer phone	

Patient Contact Information & Preferences

Address	
Home phone	
Work phone	
Cell phone	
Email:	
Phone messages ok?	Home? Work? Mobile?
Medical records access allowed to	Name: Relation: Phone:
Emergency contacts	Name: Relation: Phone:
Caregivers	

Primary Insurance

Insurance company	
Policy/Member #	
Group/Plan #	
Policy holder name	
Policy holder relation	
Policy holder birthdate	
Copay amount	
Is a referral required?	
Claims Address	
Prescription card number	
Mail-order pharmacy phone number	

Secondary Insurance

Insurance company	
Policy/Member #	
Group/Plan #	
Policy holder name	
Policy holder relation	
Policy holder birthdate	
Copay amount	
Is a referral required?	
Claims Address	
Prescription card number	
Mail-order pharmacy phone number	

Tertiary Insurance

Insurance company	
Policy/Member #	
Group/Plan #	
Policy holder name	
Policy holder relation	
Policy holder birthdate	
Copay amount	
Is a referral required?	
Claims Address	
Prescription card number	
Mail-order pharmacy phone number	

Preferred Pharmacy

Name	
Address	
Phone	

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Name:

Living Will & Power of Attorney

Have a living will?	
Medical Power of Attorney to make medical decisions on your behalf?	Name: Relation: Phone:

Reports by NavigatingCancer & Blood Disorders

Name:

MEDICAL HISTORY REPORT

Patient Overview

Nickname	
Understanding of reason for visit	
Birthdate	
Gender	
Ethnicity/Race	/
Preferred language	
Spoken languages	
Read languages	
Level of education	
Marital status	
Caregivers	
Primary care physician	
Referring physician	
Other care provider	
Other care provider	

Employment

Employment Status		
Employer		
Employer Address		
Employer Phone		
Occupation 1		
Dates	From:	To:
Occupation 2		
Dates	From:	To:
Military service:	From:	To:

Cancer & Blood Disorder History

Have you ever been diagnosed with cancer or a blood disorder? Circle one: Yes / No

Diagnosis	Date	Doctor	Chemo	RT	Sur	Alt	Additional Comments

Other Diagnoses & Medical Conditions

Diagnosis	Date	Additional Comments

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Name:

Past Surgeries & Hospitalizations

Have you ever been hospitalized or had any surgeries? Circle one: Yes / No

Surgeries

Type of surgery:	Date	Hospital/Doc/Notes:

Hospitalizations

When	Where	Reason

Allergies

Have you ever had an adverse reaction to IV dye used for X-ray studies?

Do you have any allergies? Circle one: Yes / No

Allergic to	Reaction:

Medications

Are you currently taking any prescriptions, over-the-counter medications, or alternative medications on a regular basis? Circle one: Yes / No

Medication	Frequency	Dosage	Started on	Stopped on

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Name:

Tests & Procedures

Test	Date	Location	Provider	Abnormal	Results/Notes
Last mammogram (female)					
Last PAP smear (female)					
Last PSA test (male)					
Last colonoscopy or sigmoidoscopy					
Last prostate exam (male)					
Last bone density scan					
Biopsy					

Immunizations

Type	Date	Comments

Female History

Menstrual Period History

Age at first menstrual period	
Last menstrual period	
Reason period stopped	
Notes	

Pregnancy History

Ever been pregnant	
Number of pregnancies	
Number of births	
Age at first birth	
Age at last birth	
Notes	
Breastfed	
Currently pregnant	
Could be pregnant	
Trying to get pregnant	

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Name:

History of Hormone Use

Have you ever taken birth control hormones? (i.e. pill, patch, injection)

Have you ever taken medication to increase your chance of pregnancy?

Have you ever had Hormone Replacement Therapy (HRT)?

Social & Lifestyle

Tobacco Use	Ever used?	Frequency	Number of years	Stopped?	Interested in stopping
Cigarettes					
Cigars					
Pipe					
Chewing Tobacco					

Other Substance Use	Ever used?	What kind?	Frequency	Interested in stopping
Alcohol				
Caffeinated Beverages				
Recreational Drugs				

Name:

Family Health History

Are you adopted?	
Are you of Ashkenazi Jewish descent?	
Are you of Sephardic Jewish descent?	
Twin	

Immediate Family

Relation	Name	Status	Cancer	Other illness	Notes

Do you have any biological children?

Children

Gender	Name	Status	Cancer	Other illness	Notes

Have any of your blood relatives had cancer? (include aunts, uncles, and grandparents)? Circle one: Yes / No

Extended Family

Relation	Name	Status	Cancer	Side

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Name:

Assistance

Emotional Assistance

Have you ever seen a professional for help with emotional problems? Explain.

Professional Needs

At this time, do you feel you need help with any of the following areas?

	Coping
	Financial assistance
	Nutrition
	Social work
	Home assistance
	Insurance
	Transportation
	Other

Health Maintenance

Date of last family doctor visit	
Date of last dental exam	
Recent dermatologist visit	Circle One: Yes / No Date: Reason:
Exercise frequency	
Diet	Circle one: diabetic liquid regular vegetarian
Mobility device used	Circle one: cane walker wheelchair none
Describe any assistance needed for daily activities	
Do you have transportation to your office appointments?	
Do you have family/friends to assist with your needs?	
Are you in an assisted-living environment? If so, which one?	
Do you live alone?	
Are you currently under hospice care? If so, which one?	
Religious beliefs you would like us to be aware of	

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Name:

REVIEW OF SYSTEMS

General	Y	N
Fatigue		
Pain		
Leg pain, walking		
Leg pain, resting		
Fever/chills		
Night sweats		
Weight gain		
Loss of appetite		
Unplanned weight loss		
Change in diet		
Special diet		

Endocrine	Y	N
Increased thirst		
Heat or cold intolerant		
Hot flashes		
Nervousness		

Skin	Y	N
Dry skin		
Rashes/hives		
Abnormal coloration		
Change in moles/freckles		
Open sores		

Musculoskeletal	Y	N
Muscle pain		
Muscle cramps		
Muscle weakness		
Joint/back pain		
Swollen joints		
Bone pain		

Neurological	Y	N
Headache		
Dizziness		
Fainting spells		
Memory loss		
Seizures		
Trouble talking		
Numbness/tingling		
Coordination problems		

Psychological	Y	N
Worried/anxious		
Confused/forgetful		
Depressed		
Mood swings		
Agitated		
Panic attacks		
Difficulty sleeping		
Psychiatric problems		
Claustrophobia		

Eyes	Y	N
Eye pain		
Visual changes		
Blurred vision		
Double vision		
Red eyes		

Ears	Y	N
Ear pain		
Ear drainage		
Ringing in ears		

Mouth, Nose & Throat	Y	N
Sinus pain		
Runny/stuffy nose		
Nose bleeds		
Sore throat		
Hoarseness		
Mouth sores		

Breast/Chest	Y	N
Breast pain		
Breast changes		
Lumps		
Nipple discharge		

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Name:

Lungs & Breathing	Y	N
Cough		
Coughing up blood		
Short of breath, walking		
Short of breath, resting		
Wheezing		

Heart, Blood & Circulation	Y	N
Chest pain		
Palpitations		
Legs/arms swelling		
Ankle/foot swelling		
Bruise easily		
Bleeding problems		

Digestive/Gastrointestinal	Y	N
Yellow skin/jaundice		
Difficulty swallowing		
Nausea/Vomiting		
Vomiting blood		
Heartburn		
Abdominal pain		
Constipation		
Diarrhea		
Hemorrhoids		
Rectal bleeding		
Black stools		

Urinary	Y	N
Pain with urination		
Burning		
Dribbling		
High frequency		
Urgency		
Loss of control		
Blood in urine		
Dark urine		

Lymphatics	Y	N
Swollen glands in neck		
Groin/armpit swelling		

Men	Y	N
Trouble passing urine		
Impotence		

Women	Y	N
Vaginal dryness		
Vaginal discharge		
Abnormal vaginal bleeding		
Irregular menses		
Painful intercourse		

Physical Functioning	Y	N
Physical functioning – select one below		

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