ELECTRONIC MEDICAL RECORDS DATA COLLECTION SHEET

Patient Name: **DOB**: **Today's Date**:

Reason for Visit	*Height*	*Weight*
OBGYN	***Primary Care Physician***	***Oncologist***

Social History					
Occupation:					
Marital Status:	Single ☐	Married ☐	Divorced ☐	Separated ☐	Widowed ☐
Tobacco Use:	Never ☐	Former ☐	Year quit →		
	Current ☐		# of packs per day →		# of years →

Preferred Pharmacy Information		
Pharmacy Name	***Phone Number***	***Fax Number***

Medication Allergies	
Allergy	***Reaction***

Medications				
Medication Name	***Dose***	***Directions***	***Date Started***	***Ordering Provider***

Gynecological History	
Age of first menstrual period?	
Date your last menstrual period started?	
Are you currently pregnant? ☐ Yes ☐ No	**Are you currently Nursing?** ☐ Yes ☐ No
Age at first birth?	**How many times have you been pregnant?**
Are you menopausal? ☐ **Yes** ☐ **No**	**What age did it begin?**
How many children do you have?	
How many Girls, Ages?	**How many Boys, Ages?**
Have you ever taken hormones (birth control, hormone replacement therapy)?	
If yes – how many years did you take hormones?	**What age did you stop?**

Patient Name: **DOB:** **Today's Date:**

Cancer History Assessment	
How many Sisters do you have?	**How many Brothers do you have?**
How many Sisters does your mother have?	**How many Brothers does your mother have?**
How many Sisters does your father have?	**How many Brothers does your father have?**

Ancestry – please circle all that apply		
Western/Northern Europe	**Central/Eastern Europe**	**Ashkenazi**
Latin American/Caribbean	**Africa**	**Asia**
Near East/Middle East	**Native American**	**Other**

Family History of Cancer

	Cancer Type	Age when Diagnosis	Current Age	Alive	Died	Comments
You				N/A	N/A	
Daughter						
Daughter						
Son						
Son						
Sister						
Sister						
Brother						
Brother						
Father						
Mother						
Paternal Grandmother						
Paternal Grandfather						
Maternal Grandmother						
Maternal Grandfather						
Aunt Maternal						
Aunt Maternal						
Uncle Maternal						
Uncle Maternal						
Aunt Paternal						
Aunt Paternal						
Uncle Paternal						
Uncle Paternal						
1st Cousin (Father's Side)						
1st Cousin (Father's Side)						
1st Cousin (Mother's Side)						
1st Cousin (Mother's Side)						
Others						
Others						

Patient Name: **DOB:** **Today's Date:**

Please circle any symptoms you are currently having?

Fever

Chills

Loss of vision

Cough

Dyspnea (Shortness of Breath)

Chest Pain

Irregular Heartbeat/Palpations

Abdominal Pain

Weight Loss

Dysuria (Painful Urination)

Polydipsia (Excessive Thirst)

Weight Gain

Dizziness

Headache

Skin Rash/Skin Lesion

Bone Pain

Joint Swelling

Easy Bleeding

Easy bruising

Itching/Hives

Past Medical History					
Disease	**Yes**	**No**	**Disease**	**Yes**	**No**
Angina			**Diabetes: Type 1 ❑ or 2 ❑**		
Asthma			**Hepatitis B or C**		
Atrial Fibrillation			**HIV/AIDS**		
Bleeding disorder			**Hypertension (high blood pressure)**		
Blood Clots/ DVT			**Liver disease**		
Cancer			**Malignant Hyperthermia**		
Cardiac Arrest/ Heart Attack			**MRSA/VRE**		
Cardiac dysrthythmias			**Radiation to chest or breast area**		
Cardiac Valvular disease			**Sleep apnea**		
Cerebrovascular accident/stroke			**Thyroid disease**		
COPD/ Emphysema			**Other:**		
Coronary Artery Disease			**Other:**		

Past surgical History	
Breast Cancer Surgery? Lumpectomy or Mastectomy?	☐ Yes ☐ No What year/s?
Breast biopsies? Needle or surgical?	☐ Yes ☐ No What year/s?
Breast Augmentation, reduction, reconstruction?	☐ Yes ☐ No What year?
Have you had a hysterectomy?	☐ Yes ☐ No What year?
Have you had your ovaries removed?	☐ Yes ☐ No What year?
Other Major Surgeries?	

Patient Signature: ____ Date: ____________

Provider Signature: ____ Date: ____________