MICHIGAN STATE UNIVERSITY HEALTHTEAM

Breslin Cancer Center
MSU Hematology/Oncology

MEDICAL HEALTH HISTORY

Today's date:_____

Name:_____ Date of Birth:_____

Occupation:_____

Family Physician:_____

Reason for Referral:_____

Other Physicians involved in your care:_____

_____

Race:

_____Caucasian
_____Black or African American
_____Native Hawaiian or Pacific Islander
_____Asian
_____American Indian or Alaskan Native
_____Other _____
_____Unknown

Ethnicity:

_____Hispanic or Latino
_____Non-Hispanic
_____Unknown

Durable Power of Attorney:
Yes_____No_____
Would like information:
Yes_____No_____
Copy attached:
Yes_____No_____

Living Will:
Yes_____No_____
Would like information:
Yes_____No_____
Copy attached:
Yes_____No_____

List all medications you are taking:

NAME	DOSE	HOW OFTEN	WHEN STARTED

Allergies and Reactions:_____

Name of the Pharmacy you use:_____

Address/Telephone:_____

Have you ever been hospitalized overnight? (Omit childbirth): YES_____ NO_____

What was the reason or condition for the hospitalizations?

_____ _____

_____ _____

_____ _____

List all previous surgeries and the approximate dates (month and year):

_____ _____

_____ _____

For what health problems are you currently being treated?

_____ _____

_____ _____

Do you currently drink any alcoholic beverages such as beer, wine, or hard liquor? YES____ NO_____

If yes, how many days a week to you drink alcohol? _____

On the average day that you drink alcohol, how many drinks per day do you have? _____

In the past, has your daily amount of alcohol been greater than this? YES_____ NO_____

Has alcohol drinking ever been a problem for you? YES_____ NO_____

Have you ever smoked tobacco? YES_____ NO_____, chewed tobacco YES_____ NO_____

If yes, do you still smoke? YES_____ NO_____

How many years ago did you quit? _____

How many years have you smoked? _____

How many packs per day? NOW_____ PREVIOUSLY_____

WOMEN ONLY:

At what age did your menstrual periods begin? _____

Do you have problems with your menstrual periods? YES_____ NO_____

Have your menstrual periods stopped? YES_____ NO_____

If yes, at what age? _____

How did your natural periods stop? (CHECK ALL THAT APPLY)

_____Natural menopause

_____Removal of uterus

_____Removal of ovaries

_____Other, explain_____

Have you ever taken hormone replacement? YES_____ NO_____

Have you ever taken birth control pills? YES_____ NO_____
Have you ever been pregnant? YES_____ NO_____
Number of pregnancies:_____
Number of deliveries: _____
Age at first birth: _____

Have you ever been treated for any of the following? (CHECK ALL THAT APPLY)

	YES	NO
Cancer		
Bleeding Problems		
Blood Disease		
Heart Problems		
High Blood Pressure		
Diabetes		
Thyroid Disease		
Liver Problems		
Emphysema		
Pneumonia		
Strokes		
Seizures		

FAMILY HISTORY:

Is your mother still alive? YES_____ NO_____
If no, what was the cause of her death? _____
What was the age of her death? _____

Is your father still alive? YES_____ NO_____
If no, what was the cause of his death? _____
What was the age of his death? _____

How many brothers and sisters do you have? _____
If any are deceased, what was the cause and ages of death?
_____
_____

Is there family history of the following? (CHECK ALL THAT APPLY)

	YES	NO
Cancer		
Bleeding Problems		
Blood Disease		
Heart Problems		
High Blood Pressure		
Diabetes		
Thyroid Disease		
Liver Problems		
Emphysema		
Pneumonia		

Strokes		
Seizures		

Have you experienced any of the following? (CHECK ALL THAT APPLY)

	Yes	No	Explain
Dizziness or passing out			
Memory problems			
Vision problems			
Decreased hearing			
Difficulty swallowing			
Voice changes			
Shortness of breath			
Coughing up blood			
Pneumonia			
Cold (within the last month)			
Frequent infections			
Chest pain			
Irregular heartbeat			
Blood clots			
Leg pain with walking			
Ankle swelling			
Chronic pain in bones or joints			
Abdominal pain			
Nausea or vomiting			
Diarrhea			
Blood in the stools			
Chronic constipation			
Recent weight loss or gain			
Blood or pus in urine			
Frequent or painful urination			
Inability to control urine			
Severe depression or anxiety			
Abnormal vaginal bleeding			
Vaginal discharge			
Pain with intercourse			
Skin changes			
Unusual lumps or swelling			
Fever, chills or night sweats			
Frequent headaches			

Reviewed by: _____ Date _____
Physician Signature