



OGDENCLINIC
CANCER CENTER

PATIENT FORMS

MEDICAL RECORD RELEASE AUTHORIZATION

Name: _____

Date of Birth: _____

Age: _____

Today's Date: _____

Reason for Referral: _____

Referring Doctor: _____

Primary Doctor: _____

Medications: Please list any prescriptions or

non-prescription medication

Allergies" List any known drug allergies or

contrast material such as iodine

Medical Conditions: Diabetes, hypertension, heart

disease, lung disease or liver problems,

previous cancer

Surgery: Please list all surgical procedures you

have had performed and the approximate year

of surgery

Colonoscopy

Obstetrical History:

Last menstrual period _____

Age of 1st pregnancy _____

Number of pregnancies _____

Number of miscarriage _____

Have you ever used any hormonal

supplementation such as estrogen or premarin?

If yes, how many years? _____

When did you stop? _____

Family Medical History: Please list any significant

medical problems such as cancer or blood

diseases with your family

Mother (alive/deceased) _____

Father (alive/deceased) _____

Brothers _____

Sisters _____

Other (specify) _____

Social and Occupational History:

Marital status _____

Number of children, if any _____

Current or past occupation _____

Did or do you drink alcohol? _____

If yes, how much per week? _____

If no, when did you quit? _____

Did or do you smoke? _____

If yes, how many packs/day? _____

If no, when did you quit? _____

CONSTITUTIONAL

- Fever/Chills
- Recent 10 lb. weight change
- Profound fatigue (frequent)
- Difficulty sleeping (frequent)

OPHTHALMOLOGIC

- Visual changes (not glasses)
- Double vision

ENT

- Dizziness
- Mouth sores
- Ear pain
- Trouble hearing
- Ringing in the ear
- Persistent nosebleeds
- Sinus problems
- Persistent sore throat
- Hoarseness
- Lymph Nodes Enlarged

RESPIRATORY/LUNGS

- Shortness of breath
- Coughing up blood
- Persistent cough
- Wheezing

HEART/VASCULAR

- Chest pain/tightness
- Irregular rapid heart beat
- Ankle swelling

STOMACH/BOWEL

- Bloody stool
- Black stool
- Abdominal pain
- Constipation (frequent)
- Diarrhea (frequent)#day
- Difficulty swallowing
- Frequent heart burn
- Vomiting blood
- Nausea (frequent)
- Vomiting (frequent)
- Major appetite change

HEMOTOLOGY

- Blood Transfusion

WOMEN

- Breast lumps
- Breast pain
- Frequent sweats/hot flashes
- Vaginal discharge/bleeding
- Pelvic pain

KIDNEY/BLADDER

- Blood in the urine
- Difficulty emptying bladder
- Painful urination
- Problems with bladder control
- Burning/ Stinging/ Urgency
- Kidney/bladder infection
- Urination more then once/night

SKELETAL

- Back Pain
- Neck Pain
- Joint stiffness
- Joint pain (new)
- Joint swelling
- Weakness in arms and legs

SKIN AND HAIR

- Wounds that will not heal
- Changes in moles
- Persistent rash

NEURO

- Abnormal coordination
 - Trouble with speech
 - Severe headaches (frequent)
 - Memory loss
 - Numbness or tingling (new)
- Where _____
- Confusion

PSYCH/SOCIAL

- High anxiety
- Stressors

SCREENING

- Mamogram _____
- Dexa Scan _____
- Pelvic Exam _____
- Colonoscopy _____
- EGD _____
- Other _____

PAIN 1 2 3 4 5 6 7 8 9 10

Med Update CBC _____ Wt _____ BP _____ P _____ R _____ T _____ Pox _____
