THOMPSON CANCER SURVIVAL CENTER / THOMPSON ONCOLOGY GROUP
PATIENT INFORMATION

DEMOGRAPHIC INFORMATION

Patient Name – Last:	First:		Middle:	
If applicable, other name(s) previously on file:				
Address:	City:		State:	Zip:
Phone Number – Home:	Work:	Cell:		
Date of Birth:	Age:	Sex (Circle): M F	Race (Circle): W B Other	
Social Security Number:	E-mail Address:		Marital Status (Circle) S M D W	
Emergency Contact Name:	Phone:	Relationship to Patient		
Work Status (Circle): Full-Time / Part-Time / Retired / Other	Patient's Employer:			
Business Address:	City:		State:	Zip:
Spouse's Name:	Date of Birth	SSN:		
Spouse's Employer	Address:	City:	State:	Zip:

INSURANCE INFORMATION: OUR OFFICE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD(S)

Primary Insurance:			
Insurance Address:	City:	State:	Zip:
Insured Name:	Relationship to patient:		
Insured DOB:	Insured SSN:		
ID Number:	Group Number:		

Secondary Insurance:			
Insurance Address:	City:	State:	Zip:
Insured Name:	Relationship to patient		
Insured DOB:	Insured SSN:		
ID Number:	Group Number:		

PLEASE LIST OTHER PHYSICIAN(S) INVOLVED IN YOUR CARE OR THAT NEED YOUR RECORDS/REPORTS:

Primary Care Physician:	Phone:
Referring Physician:	Phone:
Other Physician:	Phone:
Other Physician:	Phone

Thompson Oncology Group

Patient Medical History Form

TCSC60700021 (01/2021)

Patient Name: _____ Account No. _____ DOB: _____

Patient Medical History Form (p.1): Please provide the following medical information to the best of your ability:

Date:	Age:	List any ALLERGIES TO MEDICATIONS:
What problems are you here for today?		

Past Medical History:

1. Please check the "Yes" or "No" box to indicate whether you are experiencing problems with the following:

	Yes	No			Yes	No	
Diabetes	☐	☐	_____	Kidney Problems	☐	☐	_____
Hypertension (High Blood Pressure)	☐	☐	_____	Neurological Problems	☐	☐	_____
Heart Disease	☐	☐	_____	Cancer	☐	☐	_____
Cholesterol Problem	☐	☐	_____	Anemia,Leukemia,Blood Problem	☐	☐	_____
Respiratory Problems	☐	☐	_____	Clotting Excessively	☐	☐	_____
Bleeding Disorder	☐	☐	_____	Stroke	☐	☐	_____
Stomach or Intestinal Problems	☐	☐	_____	Unexplained Liver Disease/Cirrhosis	☐	☐	_____
Allergy Problems/Therapy	☐	☐	_____	Other Medical Diagnosis	☐	☐	_____
Thyroid Problems	☐	☐	_____				

2. Please list any operations (and dates) you have ever had (including tonsils & adenoids): Last Colonoscopy _____
   Last Mammogram _____

3. Please list or provide a copy of any current medications (and amounts, times per day): We can copy your list if provided.
   (include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds):

Social History: Circle best response(s) and provide details.

Marital Status:	Single	Married	Widowed	Divorced
Tobacco Use:	Never	Former	Current	Kind, amount/packs per day _____ Quit _____
Alcohol Use:	Never	Rarely	Social	Kind, amount per day _____
Occupation:	Kind of work _____		Retired	Date of Retirement _____
Home Life:	Live alone	Live with spouse / children / other _____		
Manages Household:	Self	Spouse	Other	
Manages Finances:	Self	Spouse	Other	
Drive:	Self	Spouse	Other	
Do you have?	Living Will	Durable Power of Attorney for Health Care		

List Hazardous Exposures: _____

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses: If yes, please indicated which relative(s).

	Yes	No			Yes	No	
Heart Problems	☐	☐	_____	Stroke or Vascular Disease	☐	☐	_____
Allergy	☐	☐	_____	Respiratory Problems	☐	☐	_____
Diabetes	☐	☐	_____	Liver Disease In Family	☐	☐	_____
Cancer	☐	☐	_____	Mental Illness In Family	☐	☐	_____
Bleeding Disorder	☐	☐	_____	Clotting Problems	☐	☐	_____
Anesthesia Problems	☐	☐	_____				

Reviewed by:

Thompson Oncology Group

Patient Medical History Form

TCSC60700021 (01/2021) Date ____/____/____

Patient Name: _____ Account No. _____ DOB: _____

Patient Medical History Form (p.2): Please provide the following medical information to the best of your ability:

REVIEW OF SYSTEMS:

1. Please check the "Yes" box **only** if you are **now** experiencing the listed symptom or condition.

		Yes	No		Yes	No
GENERAL	chills	☐	☐	recent weight loss or gain	☐	☐
	fatigue	☐	☐	daytime sleepiness	☐	☐
	fever	☐	☐	decrease in appetite	☐	☐
ALLERGY	environmental allergies	☐	☐	sneezing fits	☐	☐
	foods	☐	☐	latex or tape	☐	☐
EYES	pain/pressure	☐	☐	vision changes	☐	☐
ENT	hearing loss	☐	☐	ear noises	☐	☐
	dizziness	☐	☐	lightheadedness	☐	☐
	nasal congestion	☐	☐	sinus pressure or pain	☐	☐
	hoarseness	☐	☐	problem snoring, apnea	☐	☐
	throat pain	☐	☐			
RESPIR.	cough	☐	☐	coughing blood	☐	☐
	wheezing	☐	☐	shortness of breath	☐	☐
	change in voice	☐	☐	pleurisy	☐	☐
CARDIAC	chest pain	☐	☐	palpitations	☐	☐
	wake short of breath	☐	☐	ankle swelling	☐	☐
GI	difficulty swallowing	☐	☐	heartburn	☐	☐
	abdominal pain	☐	☐	nausea/vomiting	☐	☐
	bowel irregularity	☐	☐	rectal bleeding	☐	☐
	constipation	☐	☐	yellow eyes	☐	☐
	diarrhea	☐	☐	dark urine	☐	☐
GU	frequent urination	☐	☐	painful urination	☐	☐
	blood in urine	☐	☐	prostate problems	☐	☐
HEME/LYM	swollen glands	☐	☐	sweating at night	☐	☐
	bleeding problems	☐	☐	easy bruising	☐	☐
ENDO	feel warmer than others	☐	☐	feel cooler than others	☐	☐
	increased thirst	☐	☐	increased urination	☐	☐
MSK	joint aches	☐	☐	muscle aches	☐	☐
	joint swelling	☐	☐	cold/painful hands or feet	☐	☐
SKIN	rash	☐	☐	hives	☐	☐
	itching	☐	☐	skin or hair changes	☐	☐
PSYCH	depression	☐	☐	anxiety or panic	☐	☐

PLEASE STOP HERE

☐ See attached dictation

Reviewed by:

THOMPSON ONCOLOGY GROUP
Medication List

Patient Name:	
Date of Birth: / /	**Today's Date:** / /
Allergies:	
Pharmacy:	
Pharmacy Number:	

Medication Name	Dosage	How Often	Prescribed By:

PATIENT PRIVACY AND CONFIDENTIALITY

Patient Name: _____ **DOB**: _____ **MRN#** _____
Mm/dd/yyyy (Office Use Only)

There may be occasions in which our office needs to contact you concerning your appointment, diagnostic test results, or any other situation related to your visit.
How would you prefer to be contacted: (Please mark your choice and provide numbers)

___ Home phone/answering machine: **( ) -** _____
___ Work phone / voice mail: ( ) - _____
___ Cell phone / voice mail: ( ) - _____

I also give permission for the Physician/Office Staff to speak with the following people about my care:

Name: _____ Relationship: _____ Phone: ( ) - _____

Name: _____ Relationship: _____ Phone: ( ) - _____

Name: _____ Relationship: _____ Phone: ( ) - _____

____ Release to Patient Only:
Selecting this choice indicates **I DO NOT give my permission** to the Physician/Office Staff to leave messages regarding appointments, lab/test results or any other situations related to my visit/care with anyone other than me.

Patient/Guardian Signature: _____ **Date:** _____