Texas Oncology, P.A.
Surgical Specialist

Date: _____

Patient Name:_____ Birth Date:_____ Age: _____

Reason for today's visit: _____

Past Medical History:

_____ Cancer, Breast _____ Cancer, Colon/Rectum _____ Cancer, GI

_____ Cancer, Skin _____ Cancer, Other _____

_____ Bowel Disease _____ Lung Disease _____ Heart Stents

_____ Diabetes _____ Hypertension _____ Heart Problems/Disease

_____ Myocardial Infarction _____ Migraine Headaches _____ Heart Rhythm Abnormality

_____COPD/Emphysema _____ Kidney Problems _____ Heart Failure

_____ Bleeding Disorders _____ DVT/PE _____ Stroke (CVA)/TIA

_____ other _____

Surgical History:

Surgery_____ Date/Year _____

Surgery_____ Date/Year _____

Surgery_____ Date/Year _____

Surgery_____ Date/Year _____

MEDICATIONS:

Medication_____ Dosage _____

Medication_____ Dosage _____

Medication_____ Dosage _____

Medication_____ Dosage _____

Medication_____ Dosage _____

Name:_____

Allergies/Reactions:

Allergy_____ Reaction _____

Allergy_____ Reaction _____

Allergy_____ Reaction _____

GYN History:

Age at First Child: _____

Age at Menarche _____

Currently Pregnant _____

If Post Menopausal, age at menopause _____

Date of last menstrual cycle _____

Social History:

Occupation: _____

Marital Status: _____ number of children: _____

Do you smoke ____ Yes ____ No packs per day: _____

Alcohol intake: ____ Yes ____ No ____occasional _____ moderate _____ heavy

Use of Illicit drugs? ____ Yes ____ No

Caffeine intake? ____ Yes ____ No ____ occasional ____ moderate ____ heavy

Education: _____

Live alone or with others? _____

Family History:

Relation: _____ Problem _____

Relation: _____ Problem _____

Relation: _____ Problem _____

Relation: _____ Problem _____