WELLSTAR Medical Group
Oncology
In Affiliation with Northwest Georgia Oncology Centers

NEW PATIENT HEALTH HISTORY FORM

Patient Name:_____ **Birth Date**___/___/_____**Today's Date**___/___/_____

Referring Physician:_____ **Other Physicians you see:**_____

_____

Reason for visit: _____

_____

Check any conditions you have:

Illness	Y	N	Diagnosis Year	Illness	Y	N	Diagnosis Year
High Blood Pressure				Kidney problem			
Bypass or Valve replacement				Stomach problem			
Pacemaker or Defibrillator				HIV			
Congestive Heart Failure				Hepatitis			
Heart Attack or rhythm problems				Osteoporosis			
Thyroid problem				Seizures			
Diabetes				Blood clots			
Asthma or COPD				Prior history of cancer			
Gout				Depression			

Other illness not listed above_____

Prior Surgeries:

Procedure	Y	Year	Procedure	Y	Year	Procedure	Y	Year
Gallbladder			Spleen			Colon		
Uterus			Lumpectomy			Joint replacement		
Ovaries(one)			Mastectomy			Prostate		
Ovaries (both)			Stomach Bypass					

Health Maintenance: Fill in all that apply

Procedure	Date	Procedure	Date
Colonoscopy		Prostate Exam	
Mammogram		Pap Smear	

Gynecologic History: Fill in all that apply

First menstrual period age? _____ Last menstrual period (menopause) age? _____ Number of pregnancies _____

Birth control pills ☐ Yes ☐ No Hormone replacement therapy ☐ Yes ☐ No

Patient Name_____**DOB**_____

Social History:

Tobacco Use ☐ **Yes (Please explain below)** ☐ **No and Never have**

Type	Packs per day/How Often?	How many years?	Type	How Often?	How many years?
Cigarettes			Cigar		
Pipe			Chewing tobacco		

Do you drink alcohol? ☐ **No** ☐ **Yes** ☐ **Occasionally** ☐ **Daily** ☐ **Beer/Wine** ☐ **Hard Liquor**

Marital Status: **Please circle one** **Single** **Married** **Life Partner** **Divorced** **Widowed**

Occupation_____

Family History:

Family Member	Alive	Deceased	Age	List Illnesses or Cause of Death
Mother				
Father				
Siblings (brother/sister)				
Other:				

Are you allergic to any medications? ☐ **Yes** ☐ **No** **Please list:**_____

_____

Medications: List all medicines and supplements you take:

Name	Start Date	Dose	How often?	Reason

_____

Patient Signature **Date**