

CEDAR VALLY MEDICAL SPECIALISTS, P.C.
ONCOLOGY/HEMATOLOGY 200 E. RIDGEWAY
WATERLOO, IA

NAME _____ BIRTH DATE ____/____/____ AGE _____
PRIMARY DOCTOR _____ REFERRED BY _____
REASON FOR TODAY'S VISIT _____

HAVE YOU EVER BEEN ON HORMONES OR BIRTH CONTROL PILLS? YES NO
ARE YOU ON HORMONES YES NO

PAST MEDICAL HISTORY

| YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | CANCER: WHAT TYPE _____ WHEN TREATED? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | LUNG DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | COLON POLYPS/COLON CANCER |
| <input type="checkbox"/> | <input type="checkbox"/> | DIABETES |
| <input type="checkbox"/> | <input type="checkbox"/> | HIGH BLOOD PRESSURE |
| <input type="checkbox"/> | <input type="checkbox"/> | HEART DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | KIDNEY DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | COLITIS/CROHN'S DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | TUBERCULOSIS |
| <input type="checkbox"/> | <input type="checkbox"/> | HEPATITIS/LIVER DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | REFLUX-HIATAL HERNIA |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER |

PREVIOUS SURGERIES

| YES | NO | |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | BACK |
| <input type="checkbox"/> | <input type="checkbox"/> | TONSILS |
| <input type="checkbox"/> | <input type="checkbox"/> | APPENDIX |
| <input type="checkbox"/> | <input type="checkbox"/> | GALLBLADDER |
| <input type="checkbox"/> | <input type="checkbox"/> | HERNIA |
| <input type="checkbox"/> | <input type="checkbox"/> | BREAST |
| <input type="checkbox"/> | <input type="checkbox"/> | HYESTERECTOMY |
| <input type="checkbox"/> | <input type="checkbox"/> | TUBAL LIGATION |
| <input type="checkbox"/> | <input type="checkbox"/> | D & C |
| <input type="checkbox"/> | <input type="checkbox"/> | BYPASS SURGERY |
| <input type="checkbox"/> | <input type="checkbox"/> | VASCULAR SURGERY |
| <input type="checkbox"/> | <input type="checkbox"/> | ANGIOPLASTY |

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY HAD CANCER? YES NO
IF YES, WHAT TYPE _____ RELATIVE _____ AGE _____
HAVE YOU EVERY BEEN DIAGNOSED WITH A BLOOD DISORDER? YES NO _____
HAS ANYONE IN YOUR FAMILY HAD A BLOOD DISORDER? YES NO _____
IS YOUR FATHER LIVING? YES NO AGE AT DEATH ____ CAUSE OF DEATH _____
IS YOUR MOTHER LIVING? YES NO AGE AT DEATH ____ CAUSE OF DEATH _____
BROTHERS: NO. LIVING ____ NO. DEAD ____ CAUSE OF DEATH _____
SISTERS: NO LIVING ____ NO. DEAD ____ CAUSE OF DEATH _____
CHILDREN: NO. LIVING ____ AGES / HEALTH _____
CHILDREN: NO. DEAD ____ AGES / CAUSE _____

