RUTGERS
Cancer Institute
of New Jersey

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

# Health History

**Programs at Plum Street:**
**Brain and Spine Tumors**
**Head and Neck/Otolaryngology**
**Advanced Neurosurgery**

Please answer the following questions and bring this form to your first appointment at Rutgers Cancer Institute of New Jersey's Programs at Plum Street: Brain and Spine Tumors, Head and Neck/Otolaryngology, and Advanced Neurosurgery. This information will help your healthcare team plan your care.

Appointment Date: Appointment Time:

| | |
|---|---|
| Name: | Date of Birth: |
| Primary Care Physician: | Primary Care Physician's Phone: |
| Primary Care Physician's Address: | |
| Referring Physician: | Referring Physician's Phone: |
| Reason for Visit: | |
| | |
| | |

**Do you have any X-rays, MRIs or CTs?** ❑ **Yes** | ❑ **No**

| | |
|---|---|
| **Did you bring them?** ❑ **Yes** \| ❑ **No** | **Did you bring a report?** ❑ **Yes** \| ❑ **No** |

**Do you have any Medical Problems?**
❑ **Yes** *(If Yes, Please list. For example: high blood pressure, diabetes, headaches, etc.)* | ❑ **No**

**Surgical History:** *Please List All Operative Procedures, Dates and Doctors*

| Type of Surgery: | When: | Doctor: |
|---|---|---|
| | | |
| | | |
| | | |

**Do you have any allergies to medications?** ❑ **Yes** | ❑ **No**

| Which Medications? | What are the Reactions? |
|---|---|
| | |
| | |

**Pharmacy:**

| | |
|---|---|
| Pharmacy Name: | Pharmacy Telephone: |
| Pharmacy Address: | |

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Patient Name: Date:

## Medications:

**Are you currently taking any medications?** ❑ **Yes** | ❑ **No** *(Please list all medications)*

| Medication: | Dosage: | How Often Taken? *(e.g., once, twice, three or four times a day?)* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Family History:

| Relation: | Age: | Medical Problems | Deceased Age: | Cause: |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| Sisters | | | | |

## Social History:

| | | | |
|---|---|---|---|
| Marital Status: | | | Number of Children: |
| Occupation: | | | |
| Are you Unemployed? ❑ Yes \| ❑ No | | Are you on Disability? ❑ Yes \| ❑ No | |
| Do you smoke? ❑ Yes \| ❑ No | | Number of Packs a Day? | Number of Years? |
| Do you drink? ❑ Yes \| ❑ No | | Number of Drinks a Day? | Number of Years? |

## Personal Medical History: *Please check Yes or No if you have had any problem with the following*

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Frequent or Severe Headache | | | Dizziness on Changing Position | | | | | |
| Fainting Spells | | | Unconscious Spells | | | | | |
| **Eyes:** | **Yes** | **No** | | **Yes** | **No** | | **Yes** | **No** |
| Blurred Vision | | | Spots Before Eyes | | | Pain Behind Eyes | | |
| Double Vision | | | Infected Eyes | | | Change in Vision | | |
| Last Eye Exam — Date: | | | | | | | | |
| **Ears & Nose:** | **Yes** | **No** | | **Yes** | **No** | | **Yes** | **No** |
| Earaches | | | Recurrent Nose Bleeds | | | Decrease in Hearing | | |
| Discharge from Ears | | | Ringing in Ears | | | Do You Wear Glasses? | | |
| **Shortness of Breath On:** | **Yes** | **No** | | **Yes** | **No** | | **Yes** | **No** |
| Walking Several Blocks | | | Climbing One Flight of Stairs | | | Lying Down | | |
| | **Yes** | **No** | | **Yes** | **No** | | | |
| Purple Lips or Fingers | | | Palpitations or Fluttering of Heart | | | | | |
| High Blood Pressure | | | Leg Cramps on Walking or at Night | | | | | |
| | | | Swelling of hands, feet or ankles | | | What time of day? | | |

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Patient Name: Date:

## Other Comments:

## List of Current Physicians:

| | |
|---|---|
| Primary Care Physician: | |
| Address / City / State: | |
| Phone: ( ) | Fax: ( ) |
| Physician Name: | |
| Address / City / State: | |
| Phone: ( ) | Fax: ( ) |
| Physician Name: | |
| Address / City / State: | |
| Phone: ( ) | Fax: ( ) |
| Physician Name: | |
| Address / City / State: | |
| Phone: ( ) | Fax: ( ) |
| Physician Name: | |
| Address / City / State: | |
| Phone: ( ) | Fax: ( ) |
| Physician Name: | |
| Address / City / State: | |
| Phone: ( ) | Fax: ( ) |