-------------------------Health History-------------------------

Personal Information					
Name:					
Address:					
City:				State:	Zip:
Home Phone:	Business Phone:		Cell Phone:		
E-mail Address:					
Sex: ☐ Male ☐ Female	Date of Birth:		Age:		
Person to Notify in Emergency:					
Relationship:		Phone:			
Physician Name:		Phone:			

Medical History		
Check all below that apply to you. For each checked item, include a brief explanation and date of occurrence.		
	Rheumatic fever / heart murmur	
	High blood pressure	
	Chest discomfort	
	Heart abnormalities (racing, skipping)	
	Abnormal ECG	
	Heart problems	
	Coughing up blood	
	Stomach or intestinal problems	
	Anemia	
	Stroke	
	Sleeping problems	
	Migraine or recurrent headaches	
	Dizziness or fainting spells	
	Leg pain after walking short distances	
	Back/neck pain/injuries	
	Foot/ankle problems	
	Knee/hip problems	
	Lymphedema	
	High cholesterol	
	Diabetes	
	Thyroid problems	
	Lung disease	
	Respiratory problems/asthma	
	Chronic or recurrent cough	
	Disease of arteries	

	Varicose veins	
	Increased anxiety/depression	
	Recurrent fatigue	
	Arthritis	
	Swollen/stiff/painful joints	
	Epilepsy	
	Vision/hearing problems	
Women Only		
	Currently Pregnant	
	Menstrual irregularities	
	Number of children	
	Most Recent Mammogram Date	Date:
	Most Recent Pelvic Exam / PAP Date	Date:
	Breast Self Exam	☐ Yes ☐ No
Operations Starting With Most Recent		
1		Date:
2		Date:
3		Date:

Hospitalizations Starting With Most Recent			
1		Date:	Length:
2		Date:	Length:
3		Date:	Length:

Family Medical History

	Condition	Family Member(s)
	High blood pressure	
	Heart attack	
	Heart surgery	
	High cholesterol	
	Stroke	
	Diabetes	
	Obesity	
	Early death	
	Cancer	
	Other family illnesses	

General Medication Information (not cancer related)
Attach separate page if necessary

	Current Medication	Dosage
1		
2		
3		
4		

Drug Allergies:

Cancer Specific History	
Type of Cancer:	Date of Diagnosis:
Specific Location: (left/right breast, area of brain, etc.)	
Presenting Symptoms: (symptoms that led to cancer diagnosis)	
Cancer Surgery:	☐ Yes ☐ No
Type of Surgery:	Date(s) of Surgery:
Currently Undergoing Chemotherapy:	☐ Yes ☐ No
Duration:	Date of Last Treatment:
Currently Undergoing Radiation:	☐ Yes ☐ No
Duration:	Date of Last Treatment:
Currently Undergoing Nuclear:	☐ Yes ☐ No
Duration:	Date of Last Treatment:
Cancer Complications: (infection, recurrence, etc.)	
Current Medical Concerns Due to Cancer:	
Medications for Cancer: Attach Separate Page if Necessary	
Other Medications: (prescribed, OTC, vitamins, herbs, etc.)	
Primary Care Physician at Time of Diagnosis:	
Surgeon:	
Oncologist:	
Radiation Oncologist:	

Lifestyle / Activity Evaluation				
Smoking				
1	Have you ever smoked cigarettes, cigars, pipe?	☐ Yes	☐ No	Type:
2	Do you currently smoke?	☐ Yes	☐ No	Amount:
3	If you smoke, at what age did you start?			
4	If you quit, at what age did you quit?			
Diet				
1	Do you consider yourself overweight?	☐ Yes	☐ No	
	If yes, how long have you been overweight?			
2	How many meals do you typically eat per day?			
3	How often do you eat outside the home?			
Alcohol & Caffeine Use				
1	How many cups of caffeinated beverages do you consume per day?			
2	How many units of alcohol do you consume per week?			
Stress				
1	Do you consider your days stressful?	☐ Yes	☐ No	
	If yes, what is the nature of your stress?			
2	How many hours do you sleep per night?			
3	Is your sleep sound?	☐ Yes	☐ No	
4	Do you practice any form of meditation?	☐ Yes	☐ No	
	If so, describe.			
Exercise				
1	Do you exercise on a regular basis?	☐ Yes	☐ No	
2	What exercises do you participate in regularly?			
3	How many days per week do you exercise regularly?			
4	What Orthopedic problems do you have or have you had in the past?			
5	Are there any activities or exercises your physician has advised you to AVOID?			

For Ho’ola Staff Use Only	
Reviewed By:	
Date Reviewed:	