



Coastal Cancer Center Medical History Update

MRN: _____

Medical History Update

Last: _____ First: _____ DOB: _____

Chief Complaint and History of Present Illness: What is the main reason for your visit today? _____

List any new problems or symptoms within the past 12 months:

List any new hospitalizations or procedures within the past 12 months:

List any new allergies, (drugs, food, pollens, etc.), within the past 12 months:

Item	Describe reaction you had

List any changes in family or social history, (marital, smoking, new diagnosis, etc.), within the past 12 months:

When was your last Flu vaccination? _____

Please discuss with your care team member any changes in your medications within the past 12 months.

Primary Care Physician (First & Last Name): _____

City/State: _____ Phone : _____

Other Physician: _____ Specialty: _____

City/State: _____

Pharmacy: _____ Phone: _____

Do you have a living will or AD? ____ Yes, if yes, provide a copy. ____ No If no, would you like to receive information? ____ Yes ____ No

Do you have a DNR? ____ Yes, if yes, provide a copy. ____ No If no, would you like to receive information? ____ Yes ____ No

Do you have a Health Care Durable Power of Attorney? ____ Yes, if yes, provide a copy. ____ No If no, would you like to receive information? ____ Yes ____ No

Patient Signature

Date

Physician Signature

Date