CULICCHIA
NEUROLOGICAL CLINIC
Complete Neuro-Care for the Gulf South

Neuro-Oncology Patient History

Please fill out this form as completely as possible and bring to your appointment

Name: _____ Age:___ Date of Birth:_____ Height:_____ Weight:_____
Name of referring physician:_____
Reason for visit:_____
What type of work do you do?_____ **Are you currently disabled?** ☐ Yes ☐ No

Current Medication List (including non-prescription medications, over the counter supplements, etc)

Medication Name	Dose (mg)	Times per day	Month/Year started taking

Allergies (medications, dyes, foods, other):_____

Pharmacy Information

Pharmacy Name:_____
Address:_____
City:_____ State:_____ Zip:_____ Phone # (____)_____

Past Medical History:

☐ High Blood Pressure	☐ Migraine Headaches	☐ Anemia	☐ Alcohol Abuse
☐ Heart Disease	☐ Seizure Disorder	☐ Blood Clots	☐ Mental Illness
☐ Diabetes	☐ Dementia	☐ Bleeding Disorder	☐ Drug Abuse
☐ High Cholesterol	☐ Arthritis	☐ Osteoporosis	☐ Depression
☐ Stroke	☐ Rheumatoid Arthritis	☐ Glaucoma	☐ Cancer
☐ Kidney Disease	☐ Bronchitis	☐ Asthma	☐ Thyroid Disease
☐ Acid Reflux/Ulcer	☐ Liver disease	☐ HIV/AIDS	☐ Leukemia/Lymphoma
☐ Gout	☐ Aneurysm	☐ Vascular Disease	☐ Macular Degeneration
☐ Allergies	☐ Anxiety	☐ COPD (lung disease)	☐ Lupus
☐ Tuberculosis (TB)	☐ Muscle disease	☐ Nerve disease	☐ Neuropathy
☐ Alzheimer's	☐ Emphysema	☐ Hepatitis	

Other: _____

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Gynecological History (For Female Patients Only):

Do you still have menstrual periods?

☐ Yes Last menstrual period: _____/_____/_____(mm/dd/yyyy)

☐ No Why not?

☐ Ablation
☐ Breastfeeding
☐ Chemotherapy
☐ Hormonal Contraception
☐ Hormone Suppressed
☐ Hysterectomy
☐ Implant
☐ Injection
☐ Intrauterine Device
☐ Postmenopausal
☐ Post-Partum
☐ Pregnant (Estimated Delivery Date:___ /___ /___)
☐ Radiation
☐ Don't Know
☐ Other (describe): _____

Previous Hospitalizations and/or Surgeries:

Year	Illness or Operation	Year	Illness or Operation	Year	Illness or Operation

Have you ever had a transfusion or been exposed to other blood products? ☐ Yes ☐ No

If yes, please describe the circumstances:_____

_____

_____

Cancer History

Please check any previous and/or current cancers you have been diagnosed with

☐ Bladder Cancer
☐ Bone Cancer
☐ Brain Cancer
☐ Breast Cancer
☐ Cervical Cancer
☐ Colon Cancer
☐ Esophageal Cancer
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Ovarian Cancer
☐ Uterine Cancer
☐ Pancreatic Cancer
☐ Prostate Cancer
☐ Skin Cancer
☐ Small Intestine Cancer
☐ Stomach Cancer
☐ Other cancer(s): _____

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Previous Cancer Treatment(s)

Type of Cancer	Type of Treatment
	Surgery ☐ No ☐ Yes (what kind?) ____________ Chemotherapy ☐ No ☐ Yes (what agents?) ____________ Radiation ☐ No ☐ Yes (to where?) ____________ Hormonal therapy ☐ No ☐ Yes Other (specify): ____________
	Surgery ☐ No ☐ Yes (what kind?) ____________ Chemotherapy ☐ No ☐ Yes (what agents?) ____________ Radiation ☐ No ☐ Yes (to where?) ____________ Hormonal therapy ☐ No ☐ Yes Other (specify): ____________
	Surgery ☐ No ☐ Yes (what kind?) ____________ Chemotherapy ☐ No ☐ Yes (what agents?) ____________ Radiation ☐ No ☐ Yes (to where?) ____________ Hormonal therapy ☐ No ☐ Yes Other (specify): ____________

Have you had a pneumonia vaccination? ☐ Yes ☐ No
Have you had a shingles (herpes zoster) vaccination? ☐ Yes ☐ No
Have you had a flu shot? ☐ Yes ☐ No

Do you have an Advanced Directive (Living Will)? ☐ Yes ☐ No

Social History

Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Significant Other ☐ Single
☐ Widowed ☐ Unknown ☐ Other (specify): ____________
I currently live: ☐ Alone ☐ With Family ☐ With Friends ☐ With Significant Other
Do you have children? ☐ No ☐ Yes Ages:____________
What is your occupation?____________

Do you drink caffeinated beverages? ☐ Yes ☐ No
If yes, what type of beverage? ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks ☐ Other______
How much do you drink per day? ____________

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Tobacco, Alcohol, and Drug Use History

Check one of the following about smoking tobacco:

☐ Never smoked
☐ Former smoker
☐ Smoke sometimes, but not daily
☐ Smoke every day
☐ Exposed to second hand smoke

If you smoke, or used to smoke, how many packs do/did you smoke per day? _____
How many years did you smoke/have you smoked? _____
If you quit, when did you quit? _____

Do you use "smokeless tobacco"? (Select one below)

☐ Never used ☐ Former user ☐ Current user
Type? ☐ Snuff ☐ Chew

If you quit, when did you quit? _____

Are you ready to quit smoking and/or using smokeless tobacco? ☐ Yes ☐ No

Alcohol History

Do you ever drink alcohol? ☐ Yes ☐ No

If yes, please indicate the quantity per week of each:

- Glasses of wine_____
- Cans/bottles of beer_____
- Shots of liquor_____
- Drinks containing 0.5 oz of alcohol_____

Illicit/Recreational Drug Use History

Do you use drugs? ☐ Yes ☐ No

If you use drugs, how many times per week?_____
What type(s) of drugs do you use?_____
_____

Sexual History

Are you sexually active? ☐ Yes ☐ No ☐ Not Currently

If yes, is/are your partner(s): ☐ Male ☐ Female ☐ Both

Type of birth control/protection currently used:

☐ Not having sex (abstinence) ☐ Condom ☐ IUD (Intrauterine device) ☐ Partner Vasectomy
☐ Oral Contraceptive Pill ☐ Patch ☐ Post-menopausal ☐ None
☐ Tubal Ligation ☐ Injection ☐ Vasectomy
☐ Other (specify):_____

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Family History

Have any of your relatives had:

	Father	Mother	Sibling	Child	Grandmother	Grandfather
Alcohol Abuse	☐	☐	☐	☐	☐	☐
Alzheimer's/Dementia	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Anesthesia Problems	☐	☐	☐	☐	☐	☐
Aneurysm	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Leukemia	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐
Lymphoma	☐	☐	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Migraine Headache	☐	☐	☐	☐	☐	☐
Multiple Myeloma	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐
Sarcoma	☐	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐

Other (specify): _____

_____

_____

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Patient Provider Information

Family physician:

Name			Specialty
Address			Phone Number
City	State	Zip	Fax

Neurosurgeon:

Name			Specialty
Address			Phone Number
City	State	Zip	Fax

Radiation Oncologist:

Name			Specialty
Address			Phone Number
City	State	Zip	Fax

Medical Oncologist:

Name			Specialty
Address			Phone Number
City	State	Zip	Fax

Other physician:

Name			Specialty
Address			Phone Number
City	State	Zip	Fax

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