Emerald Coast Cancer Center
1024 Mar Walt Drive
Fort Walton Beach, FL 32547
Phone: 850-863-3148
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Please fill out the following form in order to assist us with the move to our new medical records system.
Thank You.

Patient Name: ______________________________ **Date Of Birth:** ____________

Tobacco Use and Cessation Counseling

Tobacco Use

_____ Non Smoker _____ Current Every Day Smoker _____ Current Some Day Smoker _____ Heavy Tobacco Smoker

_____ Light Tobacco Smoker _____ Former Smoker _____ Pipe Smoker _____ Chews Tobacco _____ Snuff User

_____ User of Moist Powdered Tobacco _____ Never Smoker _____ Years Discontinued _____ Number of Years of Use

_____ Pack(s) Per Day _____ Pack(s) Per Year History

Type: _____ Cigarettes _____ Cigars _____ Pipe _____ Smokeless Tobacco
_____ E-Cigarettes

Smoking Cessasion Counseling

_____ N/A _____ Advised to Quit _____ Discussed Cessation Methods _____ Discussed Cessation Medications

_____ Not Discussed

Alcohol

_____ Never _____ Current _____ Social _____ Former

If Former Please Provide Date Stopped ______________________

_____ Drinks Per Day _____ Drinks Per Month

Type: _____ Wine _____ Beer _____ Spirits

Recreational Drug Use

_____ Yes _____ No

Marital Status

_____ Never _____ Single _____ Married _____ Partnered _____ Separated
_____ Divorced _____ Widowed

Children

_____ Yes _____ No If Yes, How Many Children Do You Have? _____

Occupation/Employment

_____ Full Time Employment _____ Part Time Employment _____ Retired _____ Disabled

_____ Full Time Student _____ Part Time Student _____ Never Employed _____ Other or N/A

If currently employed please list current occupation: ____________________

If retired or disabled please list former occupation: ____________________

Secondary occupation (if applicable) ____________________

Occupation Exposure

_____ Not Evaluated _____ No Occupational Exposure _____ Occupational Exposure

_____ N/A

If so what type of occupational exposure? ____________________

Gynecological History

Menstrual History

_____ Age at First Menstration _____ Age at Menopause

_____ Regular Menstral Flow _____ Irregular Mentral Flow

_____ Normal Flow _____ Light Flow _____ Heavy Flow

_____ Date of Last Menstral Period

Maternity

_____ How Many Pregnancies _____ How Many Live Births

_____ Age at First Full Term Pregnancy

Breastfed- _____ Yes _____ No

Hysterectomy

_____ Yes _____ No

If Yes: _____ Partial Hysterectomy _____ Complete Hysterectomy

Hormone Use

_____ None _____ Birth Control _____ Number of Years Taken ____________ Type

_____ Continued Use _____ Year Stopped

_____ Hormone Replacement Therapy _____ Number of Years Taken ____________ Type

_____ Continued Use _____ Year Stopped ____________ Other

Health Maintenance

Colonoscopy

_____ Never OR _____ Date of Last Colonoscopy

Please List the Physician That Performed Your Last Colonoscopy ____________________

Stomach Scope (EGD)

_____ Never OR _____ Date of Last Stomach Scope (EGD)

Please List the Physician That Performed Your Last Stomach Scope (EGD) ____________________

Mammogram

_____ Never OR _____ Date of Last Mammogram

Please List the Physician or Facility That Performed Your Last Mammogram ______________________________

Monthly Self Breast Exam

_____ Yes _____ No _____ Sporadic

Pap Smear

_____ Never OR _____ Date of Last Pap Smear

Please List the Physician That Performed Your Last Pap Smear ______________________________

Bone Density

_____ Never OR _____ Date of Last Bone Density

Facility Bone Density Done At: ______________________________

Vaccination Record

Influenza (Flu Shot) _____ Yes _____ No ____________ Date of Influenza (Flu) Shot

Shingles _____ Yes _____ No ____________ Date of Shingles Vaccination

Pneumovax _____ Yes _____ No ____________ Date of Pneumovax

Other Vaccination(s) ______________________________

____

____

____

Family History

Mother _____ Living _____ Deceased

If Deceased Please List Age and Cause of Death ______________________________

Father _____ Living _____ Deceased

If Deceased Please List Age and Cause of Death ______________________________