MALE PATIENT FORM

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 Cessation 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? _____

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) _____

PSA _____ Never OR _____ Date of Last PSA

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

COVID-19 _____ Yes _____ No _____ Date of COVID-19 Vaccination

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 _____