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|---|--|--|--|--|------------------|
|  | | | Patient Label | | |
| Hematology / Oncology Medical History | | | | | |
| Date: _____ | | | Medical History | | Y N Comments |
| Name: _____ | | | GENERAL | | |
| Address: _____ | | | Recent weight change | | |
| | | | Have you been in good health most of your life? | | |
| | | | SKIN | | |
| Is English your first language? Yes No if not preferred language _____ | | | Skin disease | | |
| Primary Care Physician | | | Jaundice | | |
| Dr: _____ | | | Hives, eczema or rash | | |
| Phone: _____ Fax: _____ | | | Frequent infection or boils | | |
| if different from above: | | | Abnormal pigmentation | | |
| Referring Physician: Dr _____ | | | HEAD, EYES, EARS, NOSE AND THROAT | | |
| phone: _____ | | | Eye disease or injury | | |
| What brings you to our office? _____ | | | Headaches | | |
| | | | Glasses or contact lenses | | |
| Previous Diagnosis? _____ | | | Double vision | | |
| List Current Medications: (please include herbs / supplements) | | | Glaucoma | | |
| Medication | | | Itchy eyes or nose | | |
| Dose | | | Sneezing or runny nose | | |
| x times daily | | | Nosebleeds | | |
| | | | Chronic sinus trouble | | |
| | | | Ear disease | | |
| | | | Impaired hearing | | |
| | | | Dizziness or transient episodes of unconsciousness | | |
| | | | CARDIOVASCULAR | | |
| Allergies: _____ | | | Chest pain or angina pectoris | | |
| <i>reaction</i> | | | High blood pressure | | |
| Is there a pharmacy you use often? | | | Heart trouble or heart attacks | | |
| Name: _____ | | | Heart murmur | | |
| phone() fax() | | | Difficulty walking two blocks | | |
| Who should we contact in an emergency? | | | Swelling of hands, feet, or ankles | | |
| Name: _____ Relation: _____ | | | Shortness of breath while walking or lying down | | |
| Phone number: _____ | | | Awakening in the night smothering | | |
| Can we contact you by email? Yes No | | | GASTROINTESTINAL | | |
| @ _____ | | | Peptic ulcer (stomach or duodenal) | | |
| **** Please ask the front desk for an email consent form. **** | | | Vomiting blood or food | | |
| Have you ever had a.... | | | Gallbladder disease | | |
| Y N Date | | | Liver trouble/disease | | |
| Mammogram | | | Painful or bleeding bowel movements | | |
| Colonoscopy | | | Hepatitis | | |
| Chest Xray | | | Black stools | | |
| CT or PET/CT | | | Hemorrhoids or piles | | |
| Other: _____ | | | Recent change in bowel habits | | |
| H1N1 vaccine | | | Frequent diarrhea | | |
| Flu Vaccine | | | Heartburn or indigestions | | |
| Do you CURRENTLY have a..... | | | Does food stick to throat | | |
| Y N Date Placed | | | Cramping or pain in the abdomen | | |
| Port-a-catheter placed R or L | | | | | |
| PICC line placed R or L | | | | | |

| Medical History | Y | N | Comments | Medical History | Y | N | Comments |
|--|---|---|----------|--|----------|-----------------|-------------------|
| GENITOURINARY | | | | ALCOHOL AND RECREATIONAL DRUG USE | | | |
| Loss of urine | | | | Alcohol | | | Amt./Freq. |
| Frequent urination | | | | Recreational Drugs | | | Amt./Freq. |
| Nighttime urination | | | | GYNECOLOGIC | | | |
| Burning or painful urination | | | | Age periods started | | | |
| Blood in urine | | | | Length of periods | | | |
| Kidney trouble | | | | Frequency of periods, every | | | _____ days |
| Kidney stones | | | | Date of last menstrual period | | | |
| RESPIRATORY | | | | Any pain with periods? | | | Y N |
| Flu or cold now | | | | Number of pregnancies | | | |
| Spitting up blood | | | | Number of children | | | |
| Chronic or frequent cough | | | | Ages: | | | |
| Asthma or wheezing | | | | Date of last pap smear | | | |
| Difficulty breathing | | | | Results: | | | |
| Any trouble with lungs | | | | | | | |
| Pleurisy or pneumonia | | | | | | | |
| LOCOMOTOR MUSCULOSKELETAL | | | | | | | |
| Weakness of muscles or joints | | | | | | | |
| Varicose veins | | | | | | | |
| that is relieved by rest | | | | | | | |
| Difficulty in walking | | | | | | | |
| NEUROPSYCHIATRIC | | | | | | | |
| Ever received psychiatric care | | | | | | | |
| Ever been advised to see a psychiatrist | | | | | | | |
| spells | | | | | | | |
| Convulsions | | | | | | | |
| Paralysis | | | | | | | |
| HEMATOLOGIC | | | | | | | |
| Are you slow to heal after cuts | | | | | | | |
| Blood disease | | | | | | | |
| Anemia | | | | | | | |
| Phlebitis | | | | | | | |
| Have you had difficulty with bleeding excessively | | | | | | | |
| Excessive bleeding after tooth extraction or surgery | | | | | | | |
| Have you had abnormal bruising or bleeding | | | | | | | |
| ENDOCRINE | | | | | | | |
| Thyroid disease | | | | | | | |
| Hormone therapy | | | | | | | |
| Any change in hat or glove size | | | | | | | |
| Any change in hair growth | | | | | | | |
| Have you become colder than before | | | | | | | |
| Has your skin become dryer | | | | | | | |
| Enlarged glands | | | | | | | |
| EXPOSURE TO CHEMICALS AT HOME OR WORK | | | | | | | |
| Asbestos | | | | | | | |
| Radioactive Material | | | | | | | |
| Other Chemicals | | | | | | | |
| SMOKING STATUS: (Check One): | | | | Y | N | Comments | |
| Nonsmoker | | | | | | | |
| Former greater than 1 year | | | | | | Amt./Freq. | |
| Former less than 1 year | | | | | | Amt./Freq. | |
| Current smoker | | | | | | Amt./Freq. | |