Hematology Oncology Associate of Central New York

Medical History

Name: ______________________________ Date: _________________

Male Female

DOB: _____________ Age: _________ Consult Date: ___________

Reason for today's visit: _____________________________________

____

Referring Doctor: ____

Primary Care Doctor: ____

Surgeon & Other Doctors: _____________________________________

Medical History:

Have you ever been diagnosed with any of the following conditions?

Yes No Cancer If yes, type: ___________, treatment received_____________

Yes No Heart problems if yes, describe: _________________

Yes No High blood pressure

Yes No Circulation problems

Yes No Blood Clot

Yes No GERD or Gastric Reflux

Yes No High Cholesterol

Yes No Asthma

Yes No Emphysema/COPD

Yes No Thyroid problems If yes, describe: ____________________

Yes No Diabetes (E10.09, E11.9)

Yes No Multiple Sclerosis (MS)

Yes No Rheumatoid Arthritis

Yes No Other Arthritis If yes, describe: ____________________

Yes No Depression

Yes No Anxiety

Yes No Hepatitis

Yes No Tuberculosis

Yes No Stroke

Yes No Kidney Disease If yes, describe: _____________________

Yes No Anemia

Yes No Epilepsy/Seizure

Yes No Alcoholism or Chemical Dependency

Yes No Other Medical Problems ______________________________

€ Yes €No Hearing Problems If yes, do you wear a hearing aid? € Yes € No

Name of Patient: **DOB:**

Surgical History & Hospitalizations:

Month/Year: Surgery/Reason for Hospitalization:

______________ ____

______________ ____

______________ ____

______________ ____

Ancestry: English German African Jewish other: ___________

Race: € White € Black/African American € American Indian/Alaska Native

€ Asian € Native Hawaiian/Other Pacific Islander € Other _____

Ethnicity: € Hispanic/Latino Origin € Yes € No

Female's only- GYN/Breast History:

At what age did you have your first period? ____

How many times have you been pregnant? _____

How many children have you given birth to? ____Number of Living Children_____

At what age did you give birth to your 1st child? ___ did you breast feed? Yes no

Did you ever take oral contraceptives for birth control? Yes No

If yes, at what ages & how long? _______

Have you experienced menopause yet? Yes No If yes, at what age? _______

If no, do you have regular periods? Yes No

What is the date of your last period? _______ Date of Last Pap Smear______

Do you have hot flashes or night sweats? Yes No

Have you had a hysterectomy (removal of your uterus)? Yes No

Have you had your ovaries removed? Yes No

Have you ever, or are you taking hormone replacement therapy (estrogen or progesterone)? Yes No

If yes, at what age did you begin this therapy? _____, how many years? _____

Have you ever had a breast biopsy? Yes No If yes, how many? ____

If yes, how many have been cancerous, abnormal or atypical? ___________

Do you have breast implants? Yes No If yes, for how many years? _______

Name of Patient: **DOB:**

Have you had any of the following *symptoms* listed below *in the past month*?

Symptom	Yes	No	Comment
Fatigue (unrelieved by rest)			
Fevers or chills			
Insomnia or change in sleep pattern			
Pain, if yes, where and rate on 0-10 scale			
Anxious, depressed or overwhelmed			
Numbness or tingling			Where
Dizziness or headaches or blackouts			
Memory problems or confusion			
Vision problems or hearing loss			
Seizures			
Unsteady or Weak			
Skin rash, problems or lumps/bumps			
Swollen Glands			
Bleeding or bruising			
Blood in stool or black stool			
Loss of appetite			
Weight loss (over 10 lbs in 3 months)			Lbs in months
Weight Gain			Lbs
Nausea, Vomiting or Indigestion			
Diarrhea			
Constipation			
Mouth dry, sore or swallowing problem			
Chest pain or palpitations			
Shortness of Breath			
Swelling, if yes, Where			
Cough			
Painful or Frequent Urination			
Blood in Urine			
Hot Flashes or Night Sweats			Please Clarify
Females-LMP			
Females-Vaginal Problems			
Sexual Problems			

Name of Patient: **DOB:**

Please complete the following Family History

If family history is unknown please check here □

History	Mother	Father	Sisters	Brothers	Grandparents
Blood Disorder	□ yes □ No If Yes Describe	□ yes □ No If Yes Describe	□ yes □ No First Name(s): If Yes Describe	□ yes □ No First Name(s): If Yes Describe	□ yes □ No First Name(s): If Yes Describe
Diabetes	□ yes □ No	□ yes □ No	□ yes □ No	□ yes □ No	□ yes □ No
Stroke	□ yes □ No	□ yes □ No	□ yes □ No	□ yes □ No	□ yes □ No
Heart Disease	□ yes □ No	□ yes □ No	□ yes □ No	□ yes □ No	□ yes □ No
Hypertension	□ yes □ No	□ yes □ No	□ yes □ No	□ yes □ No	□ yes □ No
Deceased, age Cause of death	□ yes □ No Age________ Cause______	□ yes □ No Age________ Cause______	□ yes □ No Age________ Cause______	□ yes □ No Age________ Cause______	□ yes □ No Age________ Cause______

Please Complete the following Family Cancer History

Please list in chart below family members who have been diagnosed with cancer. This should include family members such as: children, grandchildren, brothers and sisters, nieces and nephews, mother and father, aunts and uncles, first cousins and grandparents. Please include type of cancer (including cancer site and type if known. For example: invasive ductal breast cancer) Include only the primary site of the cancer, not metastatic sites (for example, if an individual was diagnosed with colon cancer that spread to the liver, you only need to list colon cancer) Please be sure to include age at diagnosis.

Relatives Name	Relationship to you (brother, paternal aunt)	Status □ Living □ Deceased	Current age or age at death	Cancer type	Age at time of diagnosis
Example: Joe	Maternal Uncle	X Living □ Deceased	80	Pancreatic cancer (adenocarcinoma)	75
		□ Living □ Deceased			
		□ Living □ Deceased			
		□ Living □ Deceased			
		□ Living □ Deceased			
		□ Living □ Deceased			

Name of Patient: **DOB:**

Social History:

Single Married Separated Divorced Widowed

With whom do you live? (Check all that apply)

Alone Spouse Partner Parent Children € other___________

How many living children do you have _____, ages_________

Are you currently working? No Yes full time Part time Retired Disabled

What is your current or previous occupation? ______________________________

Do you drink alcohol? No Yes did you drink alcohol in the past? No Yes

___drinks per week for ___years

Do you use any recreational drugs? No Yes Describe____________

Smoking History

Do you use tobacco products? No Yes Marijuana € No € Yes

Have you used tobacco products in the past? No Yes Age started? _____

If yes to either, please describe: cigarettes cigars chewing tobacco e-cigarettes

____ # of packs per day for ____# of years. If stopped, when did you stop? __________

Are you interested in smoking cessation assistance? Yes No

Have you ever been exposed to hazardous chemicals or radiation? Yes No

If yes, please describe: __________________________

Do you exercise routinely? € Yes € No If yes, describe__________

Dental History

When was your last dental exam? ________ Do you have dentures? ______

Do you currently have dental problems? € Yes € No ____________ Name of Dentist _______________

Do you feel safe physically and emotionally in your current relationship and home environment? Yes No

Do you have home care services? Yes No Agency Name: _________________

What do you do to manage your stress? ___________________

Would you like to see a social worker regarding anxiety, depression, family or practical concerns? Yes No

Are you the only person caring for minor children or disabled adults and unable to care for them? Yes No

Are you living alone, unable to care for yourself and without help? Yes No

Do you use complementary therapy (i.e. yoga, reiki)? €Yes € No

If yes, please describe_______________

Religious or Spiritual Practices (optional) ____________________________

Name of Patient: **DOB:**

Advanced Directives –Please provide us with a copy of your advanced directives to us for your chart

Health Care Proxy   Living Will   DNR   MOLST

I do not have Advanced Directives   I would like information on Advanced Directives

Additional information regarding advanced directives and forms are available upon request.

Drug Allergies: Yes (list below)   No Drug Allergies

Name of Drug   Reaction

______________   ____________________________________

______________   ____________________________________

______________   ____________________________________

______________   ____________________________________

Do you have an allergy to IV Contrast?   No   Yes ____________

Food or Latex Allergies   No   Yes ________________________

Immunizations

a. Month and Year of last Influenza immunization____________ N/A______
b. Month and Year of Pneumococcal immunization____________ N/A______
c. Month and Year of Shingles vaccination _____________N/A______

What pharmacy do you use? _____________________Phone:_______________

Current Medications

Name of Drug	Dose	How Often Do You Take This Medicine	Prescriber	Medication is for

(Please include over the counter medications, vitamins and supplements)

Name of Patient: **DOB:**

Do you have any implanted devices such as: defibrillator pacemaker?

Port-a-cath prosthetic hip other device: _________________________

Date of most recent x-ray and scans & Name of Imaging Center

No x-rays or imaging tests in last 24 months

Test Done	Date Test Was Done	Place Test Was Done
Chest X-Ray		
CT Scan		
Bone Scan		
Bone Density Test		
PET Scan		
MRI		
Colonoscopy		
Mammogram		
Other Relevant Imaging		

Patient Signature: _________________________________Date:______

RN Signature _______________________________Date:_______

Physician Signature ___________________________Date:______

Physician Signature ___________________________Date:______

Rev: 6/24/15 MD, 11/19/15 MD, 5/20/17 MD