OHC
SPECIALISTS IN CANCER AND BLOOD DISORDERS

PATIENT MEDICAL INFORMATION

Today's Date: _____ Last 4 digits of SSN#:_____

Last Name: _____ First Name: _____DOB: _____/_____/_____

Address: _____

Phone #: _____ Emergency Contact Name and #: _____

Gender at Birth: _____ Gender Identity: _____

Referring MD: _____ Primary Care MD: _____

Problem or Reason For Your Visit:_____

List any known allergies to medications or other substances: _____

What type of reaction do you have?_____

Email Address: _____

Your Primary Language:

_____

Communication Barriers: _____ __ Deaf __ Blind __ Mute

Interpreter Needed? __ Yes __ No

Race: __ American Indian/Alaskan Native __ Asian __ Black/African American __ White

__ Native Hawaiian/Pacific Islander __ More than one race __ Other Race

Ethnicity: __ Hispanic or Latino __ Not Hispanic or Latino

Would you like to identify a religious preference?_____

If necessary, would you agree to have a blood transfusion? __ Yes __ No

Do you have any medical advanced directives? __Yes___No

If yes, what type? __Living Will __Power of Attorney __Healthcare Surrogate

Other:_____

Social History

Do you use tobacco? __ Yes __ No __ Quit/year quit ___

If you answered "Yes" or "Quit" above, what type? __ Chewing __ Cigar __ Cigarettes __ Pipe

__ Smokeless/Vaping Number of years used: _____ How many per day? _____

Do you drink alcohol? __ Yes __ No If "Yes", how often? __ Daily __ Weekly __ Occasionally

Caffeine? __ Yes __ No If "Yes" what type? __ Chocolate __ Coffee __ Soda __ Tablets __ Tea

What is your occupation? _____ Who do you live with? _____

Screening and Prevention

Colonoscopy: Date _____ Mammogram: Date _____

Bone Density/Dexa Scan: Date _____ Pap Smear: Date _____

Pelvic Exam: Date _____

Any recent testing? _____

Which testing facility? _____

Past Medical History

Past cancer diagnosis? _____ Date:_____Diagnosis:_____

Treating Doctor:_____Which Hospital (if admitted): _____

Any recent hospitalizations? __ Yes __ No Date: _____ Facility: _____

For patients born female:

Number of: Pregnancies _____ Deliveries _____ Lost Pregnancies_____ Living Children: _____

Date of last menstrual period: _____

- ❍ Abnomal Bleeding
- ❍ AIDS/HIV
- ❍ Allergies
- ❍ Anemia
- ❍ Angina/Heart Disease/Murmur
- ❍ Arthritis/Osteoarthritis
- ❍ Asthma
- ❍ Atrial Fibrillation
- ❍ Blood Disorders
- ❍ Cancer/Type _____
- ❍ CVA/Stroke
- ❍ COPD
- ❍ Blood Clots (leg,lung)
- ❍ Bowel problems
- ❍ Breast lumps
- ❍ Coronary Artery Disease
- ❍ Depression/Anxiety
- ❍ Diabetes
- ❍ Eye Disorders/Glaucoma
- ❍ Frequent Infections
- ❍ GERD
- ❍ Hepatitis B
- ❍ Hepatitis C
- ❍ High Cholesterol
- ❍ High Blood Pressure
- ❍ Irregular PAP Smear
- ❍ Liver Disease
- ❍ Lung Problems/Cough
- ❍ Low Blood Pressure
- ❍ Liver Disease
- ❍ Lung Problems/Cough
- ❍ Kidney/Bladder Problems
- ❍ Headaches/Migraines
- ❍ Neurological Disorders
- ❍ Obesity
- ❍ Open Sores/Wounds
- ❍ Pacemaker/Defibrillator
- ❍ Peptic Ulcer Disease
- ❍ Psychiatric Issues
- ❍ Renal Disease
- ❍ Seizure Disorder
- ❍ Thyroid Disease
- ❍ Unsual Lumps

❍ OTHER: _____

Past Surgical History

Please include year surgery performed:

- ❍ Access Device: *(Please circle below)*
- ❍ Port-A-Cath / PICC / Central Line
- ❍ Appendix Removal _____
- ❍ Bone Marrow Biopsy _____
- ❍ Bone Marrow Transplant _____
- ❍ Coronary Artery Bypass Graft _____
- ❍ Cataract Extraction _____
- ❍ Gall Bladder Removal _____
- ❍ Radiation Implant _____
- ❍ Breast Biopsy _____
- ❍ Colostomy Bag _____
- ❍ Brain Surgery _____
- ❍ Bladder Removal _____
- ❍ Gastric Volvulus _____
- ❍ Needle Aspiration _____
- ❍ Colon Resection _____
- ❍ Hip Surgery _____
- ❍ Knee Surgery _____
- ❍ Lumpectomy _____
- ❍ Lymph Node Dissection ____
- ❍ Kidney Removal _____
- ❍ Omentum Removal _____
- ❍ Lung Removal _____
- ❍ Radical Neck Dissection ____
- ❍ Ommaya Reservoir _____

Gender Specific:

Female:

- ❍ C-Section _____
- ❍ D and C _____
- ❍ Hysterectomy _____
- ❍ Mastectomy _____
- ❍ Ovary Removal _____
- ❍ Ovarian Cyst Removal ____

Male:

- ❍ Testicle Removal _____
- ❍ Prostate Biopsy _____
- ❍ Prostatectomy _____
- ❍ Radical Prostatectomy ____

❍ OTHER: _____

Family History

Indicate illnesses in your immediate family and cancer type if applicable:

Diagnosis	Family Member	Diagnosis	Family Member
❍ Alcoholism	_____	❍ High Cholesterol	_____
❍ Alzheimer's Disease	_____	❍ Irritable Bowel Disease	_____
❍ Asthma	_____	❍ Mental Illness	_____
❍ Blood Diseases	_____	❍ Migraines	_____
❍ Coronary Artery Disease	_____	❍ Obesity	_____
❍ Cancer/type	_____	❍ Osteoarthritis	_____
❍ CVA/Stroke	_____	❍ Peripheral Vascular Disease	_____
❍ Depression	_____	❍ Renal Disease	_____
❍ Diabetes	_____	❍ Seizure Disorder	_____
❍ High Blood Pressure	_____	❍ Other	_____