



SPECIALISTS IN CANCER AND BLOOD DISORDERS

PATIENT MEDICAL INFORMATION

Today's date: _____ SS: (Last 4 digits): _____

Last name: _____ First name: _____ DOB: ____/____/____

Address: _____

Phone #: _____ Emergency contact name and #: _____

Gender at birth: _____ Gender identity: _____

Referring doctor: _____ Primary care doctor: _____

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? Yes No

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

Do you have any medical advance 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 _____

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

Do you have a past or current history of recreational drug use? Yes No

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? _____

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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: Age of menarche (first menstrual cycle) _____

Date of last menstrual period: _____

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

- Abnormal bleeding
- AIDS/HIV
- Anemia
- Angina/Heart disease/Murmur
- Anxiety
- Arthritis/Osteoarthritis
- Asthma
- Atrial fibrillation
- Bladder problems
- Blood clots (leg, lung)
- Blood disorders
- Bowel problems
- _____
- Breast lumps
- Cancer/Type _____
- Cough
- COPD
- CVA/Stroke
- Coronary artery disease
- Defibrillator
- Depression
- Diabetes
- Eye disorders
- Frequent infections
- GERD
- Glaucoma
- Headaches
- Hepatitis B
- Hepatitis C
- High blood pressure
- High cholesterol
- Irregular PAP smear
- Kidney problems
- Liver disease
- Low blood pressure
- Lung problems
- Migraines
- Neurological disorders
- Obesity
- Open sores/Wounds
- Pacemaker
- Peptic ulcer disease
- Psychiatric issues
- Renal disease
- Seizure disorder
- Thyroid disease
- Unusual lumps

OTHER: _____

Past Surgical History

Please include the year your surgery was performed:

- | | | |
|---|---|---|
| <input type="radio"/> Access device: <i>(Please circle below)</i> | <input type="radio"/> Hip surgery _____ | Gender Specific: |
| <input type="radio"/> Any metal implants _____ | <input type="radio"/> Kidney removal _____ | |
| <input type="radio"/> Appendix removal _____ | <input type="radio"/> Knee surgery _____ | Female: |
| <input type="radio"/> Bladder removal _____ | <input type="radio"/> Lumpectomy _____ | <input type="radio"/> C-Section _____ |
| <input type="radio"/> Breast biopsy _____ | <input type="radio"/> Lung removal _____ | <input type="radio"/> D and C _____ |
| <input type="radio"/> Breast implants _____ | <input type="radio"/> Lymph node dissection _____ | <input type="radio"/> Hysterectomy _____ |
| <input type="radio"/> Bone marrow biopsy _____ | <input type="radio"/> Needle aspiration _____ | <input type="radio"/> Mastectomy _____ |
| <input type="radio"/> Bone marrow transplant _____ | <input type="radio"/> Omentum removal _____ | <input type="radio"/> Ovary removal _____ |
| <input type="radio"/> Brain surgery _____ | <input type="radio"/> Ommaya reservoir _____ | <input type="radio"/> Ovarian cyst removal _____ |
| <input type="radio"/> Cataract extraction _____ | <input type="radio"/> Pacemaker _____ | Male: |
| <input type="radio"/> Colon resection _____ | <input type="radio"/> Port-A-Cath / PICC / Central line _____ | <input type="radio"/> Testicle removal _____ |
| <input type="radio"/> Colostomy bag _____ | <input type="radio"/> Radiation implant _____ | <input type="radio"/> Prostate biopsy _____ |
| <input type="radio"/> Coronary artery bypass graft _____ | <input type="radio"/> Radical neck dissection _____ | <input type="radio"/> Prostatectomy _____ |
| <input type="radio"/> Gallbladder removal _____ | <input type="radio"/> Stents _____ | <input type="radio"/> Radical prostatectomy _____ |
| <input type="radio"/> Gastric volvulus _____ | | |

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Family History

Indicate illnesses in your immediate family and cancer type if applicable. Please list their relationship to you (*ex. mother, father, brother, sister, aunt, uncle, cousin, paternal/maternal grandparent*).

Cancer

- | | |
|--|---|
| <input type="radio"/> Breast _____ | <input type="radio"/> Non-Hodgkins lymphoma _____ |
| <input type="radio"/> Lung _____ | <input type="radio"/> Kidney _____ |
| <input type="radio"/> Colorectal _____ | <input type="radio"/> Uterine _____ |
| <input type="radio"/> Pancreatic _____ | <input type="radio"/> Cervix _____ |
| <input type="radio"/> Malignant melanoma _____ | <input type="radio"/> Thyroid _____ |
| <input type="radio"/> Stomach _____ | <input type="radio"/> Brain/CNS _____ |
| <input type="radio"/> Esophageal _____ | <input type="radio"/> Myeloma _____ |
| <input type="radio"/> Ovarian _____ | <input type="radio"/> Liver _____ |
| <input type="radio"/> Leukemia _____ | <input type="radio"/> Bladder _____ |
| <input type="radio"/> Oral _____ | |

Heart Disease

- | | |
|---|--|
| <input type="radio"/> Coronary artery disease _____ | <input type="radio"/> Congestive heart failure _____ |
| <input type="radio"/> Myocardial infarction _____ | <input type="radio"/> Angina _____ |

Other

- | | |
|--|--|
| <input type="radio"/> Hypertension _____ | <input type="radio"/> COPD _____ |
| <input type="radio"/> Diabetes _____ | <input type="radio"/> Renal disease _____ |
| <input type="radio"/> Cerebrovascular accident _____ | <input type="radio"/> Liver disease _____ |
| <input type="radio"/> Accident _____ | <input type="radio"/> Coagulopathies _____ |