OHC
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 _____

- ❍ Abnomal 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
- ❍ Unsual lumps

❍ OTHER: _____

Past Surgical History

Please include the year your surgery was performed:

- ❍ Access device: *(Please circle below)*
- ❍ Any metal implants _____
- ❍ Appendix removal _____
- ❍ Bladder removal _____
- ❍ Breast biopsy _____
- ❍ Breast implants _____
- ❍ Bone marrow biopsy _____
- ❍ Bone marrow transplant _____
- ❍ Brain surgery _____
- ❍ Cataract extraction _____
- ❍ Colon resection _____
- ❍ Colostomy bag _____
- ❍ Coronary artery bypass graft _____
- ❍ Gallbladder removal _____
- ❍ Gastric volvulus _____
- ❍ Hip surgery _____
- ❍ Kidney removal _____
- ❍ Knee surgery _____
- ❍ Lumpectomy _____
- ❍ Lung removal _____
- ❍ Lymph node dissection _____
- ❍ Needle aspiration _____
- ❍ Omentum removal _____
- ❍ Ommaya reservoir _____
- ❍ Pacemaker _____
- ❍ Port-A-Cath / PICC / Central line _____
- ❍ Radiation implant _____
- ❍ Radical neck dissection _____
- ❍ Stents _____

Gender Specific:

Female:

- ❍ C-Section _____
- ❍ D and C _____
- ❍ Hysterectomy _____
- ❍ Mastectomy _____
- ❍ Ovary removal _____
- ❍ Ovarian cyst removal _____

Male:

- ❍ Testicle removal _____
- ❍ Prostate biopsy _____
- ❍ Prostatectomy _____
- ❍ Radical prostatectomy _____

❍ OTHER: _____

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Family History

Indicate illnesses in your immediate family and cancer type if applicable. Please list their relationship to you, not their name. ***(ex. parents, siblings, paternal/maternal grandparents, paternal/maternal aunts, uncles, and cousins.)***

Cancer

- ❍ Breast _____
- ❍ Lung _____
- ❍ Colorectal _____
- ❍ Pancreatic _____
- ❍ Malignant melanoma _____
- ❍ Stomach _____
- ❍ Esophageal _____
- ❍ Ovarian _____
- ❍ Leukemia _____
- ❍ Oral _____
- ❍ Non-Hodgkins lymphoma _____
- ❍ Kidney _____
- ❍ Uterine _____
- ❍ Cervix _____
- ❍ Thyroid _____
- ❍ Brain/CNS _____
- ❍ Myeloma _____
- ❍ Liver _____
- ❍ Bladder _____

Heart Disease

Please list anyone in your family who has had heart disease. Please list their relationship to you, not their name.
(ex. parents, siblings, paternal/maternal grandparents, paternal/maternal aunts, uncles, and cousins.)

- ❍ Coronary artery disease _____
- ❍ Myocardial infarction _____
- ❍ Congestive heart failure _____
- ❍ Angina _____

Other

- ❍ Hypertension _____
- ❍ Diabetes _____
- ❍ Cerebrovascular accident _____
- ❍ Accident _____
- ❍ COPD _____
- ❍ Renal disease _____
- ❍ Liver disease _____
- ❍ Coagulopathies _____

PATIENT LIST OF MEDICATIONS

Please list all medications that you are currently taking.

Include all over-the-counter medicines, vitamins and herbal supplements.

Please PRINT as clearly as possible.

Patient Name: _____ Date of Birth: _____

Allergies: _____

_____

Pharmacy Name: _____

Pharmacy Location: _____ Phone Number: _____

Name of Medication Brand or Generic Name	**Strength/Dosage** mg, units, puffs or drops	**Directions** How many times per day? Only as needed?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Please bring all of the medication bottles with you to your appointment so that we can do a thorough review of your medications.