OHC
SPECIALISTS IN CANCER AND BLOOD DISORDERS

OHC BREAST SURGICAL ONCOLOGY
MALE NEW PATIENT INTAKE FORM

First name: _____ Last name: _____

Today's date: _____ DOB: ____/____/____ Age: _____ SS: (Last 4 digits): _____

Reason for visit:_____

Referring doctor: _____ Primary care doctor: _____

Medical History – Please check all that apply or have applied in the past

- ❍ Headaches
- ❍ Stroke
- ❍ Thyroid problem
- ❍ Diabetes (Type I or II)
- ❍ Atrial fibrillation
- ❍ Congestive heart failure
- ❍ Heart disease/Heart attack
- ❍ High blood pressure
- ❍ High cholesterol
- ❍ Asthma
- ❍ COPD/Emphysema
- ❍ Sleep apnea
- ❍ Bleeding disorders/Anemia
- ❍ Kidney problems
- ❍ Liver problems
- ❍ Hepatitis
- ❍ HIV/AIDS
- ❍ Alcoholism
- ❍ Arthritis/Gout
- ❍ Epilepsy/Seizures
- ❍ Testicular mass/Tumor
- ❍ Lupus/SLE
- ❍ Collagen vascular disease
- ❍ Scleroderma
- ❍ Cancer (type: _____)

Please list any additional medical problems and/or surgeries you have had:

_____

_____

Please list any allergies:

_____

Have you ever taken any of the following? ❍ Yes ❍ No (Mark all that apply)

❍ Estrogen ❍ Growth hormone ❍ Steroids ❍ Herbal supplements

Do you currently take any of the following? ❍ Yes ❍ No (Mark all that apply)

❍ Aspirin ❍ Coumadin/Warfarin ❍ Eliquis ❍ Xarelto ❍ Plavix ❍ Other

Family History – Please list anyone in your family who has had cancer:

Family member with cancer (ex. parents, siblings, paternal/maternal grandparents, aunts, uncles, and cousins)	Type of cancer	Age at diagnosis	Alive, current age	If deceased, age at death

Are you of Ashkenazi Jewish descent? ❍ Yes ❍ No Mother or father's side? _____

Have you ever had any genetic testing? ❍ Yes ❍ No Year _____ Results _____

Have any family members had any genetic testing? ❍ Yes ❍ No Who and results _____

Social History

Alcohol use: ❍ Never ❍ Socially ❍ Daily # Drinks/day: _____

Current tobacco use: ❍ Yes If yes, # Cigarettes/day: ____ # of years: ____ ❍ No ❍ Former

Occupation: _____

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ohcare.com

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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.