Hematology Oncology Associate of Central New York

Medical History

Name: _____ Date: _____

□ Male □ Female

DOB: _____ Age: _____ Consult Date: _____

Reason for Consult _____

_____

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 or Liver disease If yes, describe:_____

□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 age & 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 a 0-10 scale			Where? 0-10_____
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 in _____timeframe
Nausea, Vomiting or Indigestion			
Diarrhea			
Constipation			
Mouth dry, sore or swallowing problem			
Chest pain or palpitations			
Shortness of Breath			
Swelling, if yes, Where			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_____

Name of Patient: **DOB:**

Please complete the following Family Cancer History

Please list 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 the 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			
		☐ 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 a copy of your advanced directives to us for your chart

□ Health Care Proxy □ Living Will □ DNR □ MOLST

□ I do NOT have Advanced Directives

*Additional information regarding Advanced Directives and forms are available upon request.

□ I would like information on Advanced Directives

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 immunization _____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: _____

Please indicate the date of your most recent x-ray and scans & the name of the imaging center

□ Check here if you had 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:_____

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