MOHC MEDICAL ONCOLOGY HEMATOLOGY CONSULTANTS, PA | The US Oncology Network

NEW PATIENT MEDICAL HISTORY FORM (Please complete both sides)

PATIENT NAME_____ **DATE**_____

Please list any drug/medication ALLERGIES :_____

Please name any other physicians you are currently seeing (and list their specialties):

Referring MD_____**Primary MD**_____ **Others** _____

Your physician or nurse practitioner will review this information with you. You should also be prepared for a physical exam.

MEDICAL HISTORY:

HAVE YOU EVER HAD ANY OF THE FOLLOWING *(Please check all that apply)*:

	Yes	No		Yes	No
Pneumonia	❒	❒	Diabetes	❒	❒
High cholesterol	❒	❒	Thyroid disease	❒	❒
Heart attack	❒	❒	Hepatitis	❒	❒
Stroke	❒	❒	Tuberculosis	❒	❒
Angina	❒	❒	Kidney disease	❒	❒
Stomach ulcers	❒	❒	High blood pressure	❒	❒
Other cancers	❒	❒			

HAVE YOU EVER HAD ANY OF THE FOLLOWING SURGERIES:

	Yes	No		Yes	No
Appendix	❒	❒	Hemorrhoids	❒	❒
Tonsils	❒	❒	Hernia	❒	❒
Hysterectomy	❒	❒	Heart	❒	❒
Gallbladder	❒	❒	Teeth	❒	❒
Cataracts	❒	❒	Vascular (veins/arteries)	❒	❒

Any other surgeries (please list) _____

Any hospitalizations (other than surgery or childbirth)_____

Women: **# of Pregnancies**_____ **# of Deliveries**_____ **Complications** ❒ **Y** ❒ **N**

First day of last menses_____ **Age at menopause**_____

FAMILY HISTORY:

Mother's age now_____ or age when passed away_____
Her medical problems_____

Father's age now_____ or age when passed away_____
His medical problems _____

#_____brothers/ #_____sisters any medical problems/cancers_____

Do you have relatives with any of the following (please circle):

Heart Attack Diabetes Heart Disease Stroke Blood Disorders High Blood Pressure Asthma Tuberculosis
Cancer (please list types)_____

PERSONAL HISTORY:

CANCER SCREENING:

Have you had a:

Mammogram	□ Y	□ N	please give approximate date_____
Gynecologic exam/Paps smear	□ Y	□ N	please give approximate date_____
Colonoscopy	□ Y	□ N	please give approximate date_____
Prostate exam/PSA	□ Y	□ N	please give approximate date_____

Do you:

Smoke □ Y □ N-if so, Packs per day_____ or quit smoking_____years ago

Consume Alcohol □ Y □ N-if so, # drinks per week_____ or were you ever a heavy drinker □ Y □ N

Quit drinking____years ago

Have any religious beliefs/restrictions that affect your medical care? □ Y □ N (please list)_____

Have you ever had:

Any Asbestos Exposure □ Y □ N Other Toxin Exposure □ Y □ N(please list)_____

Please List:

Present Occupation_____Previous Occupation_____

Marital Status_____With whom do you live_____

REVIEW OF SYSTEMS:

ARE YOU EXPERIENCING ANY OF THE FOLLOWING:

	Yes	No		Yes	No
Frequent headaches	❒	❒	Migraines	❒	❒
Changes in vision	❒	❒	Glaucoma	❒	❒
Sinus problems	❒	❒	Ear problems	❒	❒
	Yes	**No**		**Yes**	**No**
Weight loss #_____lbs	❒	❒	Weight gain	❒	❒
Sleep problems	❒	❒	Heavy night sweats	❒	❒
Nervousness	❒	❒	Depression	❒	❒
Appetite problems	❒	❒	Fevers	❒	❒
Painful /stiff neck	❒	❒	Sore throats	❒	❒
Thyroid problems	❒	❒	Trouble swallowing	❒	❒
	Yes	**No**		**Yes**	**No**
Bronchitis/emphysema	❒	❒	Shortness of breath	❒	❒
Coughing blood	❒	❒	Chronic cough	❒	❒
Pneumonia	❒	❒	Chest pains	❒	❒
Heart murmur	❒	❒	Palpitations	❒	❒
Angina	❒	❒	Rapid heart beat	❒	❒
	Yes	**No**			
Acid indigestion/heartburn	❒	❒		**Yes**	**No**
Gallstones	❒	❒	Nausea/vomiting	❒	❒
Pains in abdomen	❒	❒	Diarrhea/constipation	❒	❒
Hemorrhoids	❒	❒	Blood in stool	❒	❒
Liver problems/jaundice	❒	❒	Back pain	❒	❒
Kidney stones	❒	❒	Kidney infections	❒	❒
Bladder infections	❒	❒	Blood in urine	❒	❒
Frequent urination	❒	❒	Prostate problems	❒	❒
Slow urine stream	❒	❒	Waking up to urinate	❒	❒
	Yes	**No**		**Yes**	**No**
Arthritis	❒	❒	Pain/stiff joints	❒	❒
Epilepsy/seizures	❒	❒	Stroke/TIA's	❒	❒
Brief weakness of hand or leg	❒	❒	Vision loss	❒	❒
Anemia	❒	❒	Bleeding easily	❒	❒
Easy bruising	❒	❒	Moles changing color/size	❒	❒
Prior blood transfusion	❒	❒	Any skin rashes	❒	❒
Heavy menstrual flow/severe cramps	❒	❒	Irregular menstrual cycle	❒	❒