WELLNESS
ONCOLOGY HEMATOLOGY

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PATIENT CONTACT INFORMATION

Name _____ Birthdate ____/____/____ Marital Status _____

SS# _____ Race _____ Ethnicity _____ Gender ☐ F ☐ M

Address _____ City/State/Zip _____

Mobile Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Please check off your preference's on how you want to be contacted by our office below:

Alerts	Text	Email	Phone
All	☐	☐	☐
Scheduled Appointment	☐	☐	☐
Confirmed Appointment	☐	☐	☐
Follow Up Visit Alerts	☐	☐	☐
Administrative Alerts	☐	☐	☐
Clinical Reminders	☐	☐	☐
Lab Result Notifications	☐	☐	☐
Birthday Greetings	☐	☐	☐

Emergency Contact _____ Phone _____

Spouse/Partner Name _____

Employer _____

Referring Physician _____

Other physicians you want to receive medical information:

1. Primary Care Physician (PCP) _____
2. Physicians _____
3. Physicians _____

INSURANCE INFORMATION

Primary Insurance ID Number_____Group_____

Name of Policy Holder_____DOB of Policy Holder _____

Secondary Insurance ID Number_____Group _____

Name of Policy Holder_____DOB of Policy Holder _____

Please give us your prescription card and pharmacy information for authorization.

Preferred Pharmacy _____

Address_____

Phone _____

Prescription Benefits_____

RX BIN_____

RX_____

Group_____

HEALTH HISTORY INFORMATION

MEDICATION LIST: Please list current prescriptions & nonprescription medicines, vitamins, home remedies, herbs:

MEDICATION	DOSE	HOW OFTEN	FOR HOW LONG
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

ALLERGIES

Are you allergic to any medicine? □ YES □NO If yes, please list medication below

MEDICATION	TYPE OF REACTION
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

PAST MEDICAL HISTORY

☐Blood disease - Type? _____

☐Cancer - Type? _____

☐Depression ☐Blood Disease ☐Diabetes ☐Thyroid Disease

☐High Blood Pressure ☐High Cholesterol

☐Other:

1. _____

2. _____

3. _____

PAST MEDICAL HISTORY, Cont.

4. _____

5. _____

How would you rate your general health? ☐Excellent ☐Good ☐Fair ☐Poor

SURGICAL HISTORY

Have you ever had surgery? □ YES □NO If yes, please list below

TYPE OF SURGERY	YEAR
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

SOCIAL HISTORY

Do you drink alcoholic beverages? ☐ YES ☐NO

Drinks per day_____Drinks per week_____

Do you smoke now or ever in the past? ☐ YES ☐NO

If yes:

How many packs per day?_____For how many years?_____

Age when you started?_____Are you currently smoking?_____

If you quit, when did you quit_____

Total cups of coffee/ tea daily_____

Have you ever chewed tobacco now or in the past? ☐ YES ☐NO

If yes:

For how many years?_____ Age when you started?_____

Are you currently chewing tobacco? ☐ YES ☐NO

If you quit, when did you quit_____

SOCIAL HISTORY, Cont.

Have you ever smoked marijuana? ☐ YES ☐NO

Are you on a special diet? ☐ YES ☐NO What kind: _____

Do you take vitamins? ☐ YES ☐NO What kind: _____

Do you have a durable power of attorney for health care? ☐ YES ☐NO

If yes, Who: _____

Do you have an advance directive? ☐ YES ☐NO

FAMILY HISTORY

Relation	**Living?**		**Age or Age at Death**	**State of Health, or Cause of Death**
Father	Y	N	_____	_____
Mother	Y	N	_____	_____
Spouse	Y	N	_____	_____
Brothers	Y	N	_____	_____
_____	Y	N	_____	_____
_____	Y	N	_____	_____
_____	Y	N	_____	_____
Sisters	Y	N	_____	_____
_____	Y	N	_____	_____
_____	Y	N	_____	_____
_____	Y	N	_____	_____
Children	Y	N	_____	_____
_____	Y	N	_____	_____
_____	Y	N	_____	_____
_____	Y	N	_____	_____

HOW IS YOUR MOOD?

Over the last two weeks, how often have the following problems bothered you?

Please check one box to the right of each question	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling asleep or staying asleep, or sleeping to much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or hate let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around more than usual				
Thought that you would be better off dead, or of hurting yourself in some way				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people (circle one)	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

REVIEW OF SYSTEMS

GENERAL

☐Chills ☐Tiredness ☐Sweats ☐Weakness

MOUTH

☐Pain ☐Ulcers ☐Tongue: Sore, Enlarged

☐Drooling ☐Change in Taste ☐Dry Mouth

NOSE & THROAT

☐Hoarseness ☐Cough Blood ☐Shortness of Breath

☐Wheezing ☐Positive TB Skin Test ☐Night Sweats

☐Abnormal Chest X-ray ☐Cough Sputum; Color

RESPIRATORY:

☐Bronchitis ☐Dry Cough ☐Asthma ☐Pneumonia

HEMATOLOGY

☐Easy Bruising or Bleeding ☐Swollen Lymph nodes: Neck, Groin, Under Arms

GASTROINTESTINAL

☐Poor Appetite ☐Abdominal Pain ☐Food Intolerance or Allergy

☐Nausea ☐Vomiting ☐Vomiting Blood

☐Diarrhea ☐Laxative Use ☐Belching

☐Rectal Bleeding ☐Bloating ☐Change in Stool Size

☐Jaundice ☐Constipation ☐Black, White, Bloody Stool

☐Heartburn ☐Trouble Chewing ☐Hemorrhoids

☐Trouble Swallowing ☐Gallbladder Problems

NEUROLOGICAL & PSYCHOLOGICAL

☐Fainting ☐Dizziness ☐Seizures

☐Tingling ☐Numbness ☐Depression

☐Personality Change ☐Nervousness ☐Worry

☐Incoordination ☐Paralysis ☐Weakness

MUSCULOSKELETAL

☐Bone Pain ☐Muscle Pain ☐Joint: Stiffness, Pain, Redness

☐Back Pain

ENDOCRINE & METABOLISM

☐Poor Energy ☐Increased Thirst ☐Appetite Change

Recent Weight Change: ☐None ☐Loss/☐Gain _____LBS

PAIN

Are you currently experiencing any pain? _____

If yes, where is it located? _____

What is it from? _____

How intense is it? Use pain scale below.

10 BEING THE WORSE

0	1	2	3	4	5	6	7	8	9	10

What relieves or reduces it?_____

In the past few days, I would best describe my activity level as:

☐I feel Normal; no complaints; no symptoms of disease

☐I am able to carry on normal activity; minor signs or symptoms of disease

☐I can perform normal activities with effort; I note some signs or symptoms of disease

☐I can care for myself, but am unable to carry on normal activity or do active work

☐I require occasional assistance but am able to care for most of my own needs

FATIGUE

Over the past week my fatigue level has been: Use pain scale below.

10 BEING THE WORSE

0	1	2	3	4	5	6	7	8	9	10

Does your fatigue interfere in your activities of daily living? ☐ YES ☐NO

BLOOD TRANSFUSION AND DONATIONS

Have you ever had a blood transfusion ☐ YES ☐NO
If yes, when and why?_____

Any reaction?_____
Have you ever donated blood ☐ YES ☐NO

Please tell us when you had a:

Stool test for blood Date:_____

Sigmoidoscopy or colonoscopy Date:_____

GENITOURINARY

Pain with Urination or Intercourse: YES NO Dark or Red Urine

Urinate frequently during the day _____times _____

Urine Stream: ☐Weaker ☐Smaller ☐Dribbling ☐Difficulty Starting or Stopping

Incontinence_____None _____

WOMEN

Age of first Period_____Age at Menopause _____

☐Menses ☐Irregular ☐Heavy ☐Painful ☐Abnormal Bleeding
☐Discharge

Date of last Menses_____

Date of last Pap Smear _____ ☐Normal ☐Abnormal

Mammogram_____ ☐Normal ☐Abnormal

Number of Pregnancies_____Did you breast feed☐ YES ☐NO

WOMEN, cont.

☐Therapeutic Abortions ☐Miscarriages ☐Complication

☐Age at first term pregnancy

Birth control pills ☐ YES ☐NO

If yes, for how long_____when did you last take them_____

Do you have a Breast: ☐Lump ☐Discharge ☐Pain ☐Swelling

Did you ever take Diethylstilbestrol (DES) ☐ YES ☐NO

Did your mother take Diethylstilbestrol (DES) ☐ YES ☐NO

Other Hormones (such as Estrogen, etc) ☐ YES ☐NO

If yes, what? _____When_____

MEN

Prostatic Specific Antigen _____

☐Penis: Soreness, discharge, burning, Pain ☐Testicle: Pain, Swelling, Lump