SPECIALISTS IN CANCER
AND BLOOD DISORDERS

PATIENT MEDICAL INFORMATION

Today's Date: ____________________

Last Name: ______________________ First Name: ________________________ DOB: ________________________________

Referring MD: __________________________________ Primary Care MD: ____

Past Medical History

❍ AIDS/HIV
❍ Allergies
❍ Anemia
❍ Angina/Heart Disease/Murmur
❍ Arthritis/Osteoarthritis
❍ Asthma
❍ Atrial Fibrillation
❍ Blood Disorders
❍ Cancer/Type _____________
❍ CVA/Stroke
❍ COPD

❍ Coronary Artery Disease
❍ Depression/Anxiety
❍ Diabetes
❍ Eye Disorders/Glaucoma
❍ GERD
❍ Hepatitis B
❍ Hepatitis C
❍ High Cholesterol
❍ High Blood Pressure
❍ Low Blood Pressure
❍ IBS/Colitis

❍ Liver Disease
❍ Lung Problems/Cough
❍ Kidney/Bladder Problems
❍ Headaches/Migraines
❍ Neurological Disorders
❍ Obesity
❍ Pacemaker/Defibrillator
❍ Peptic Ulcer Disease
❍ Psychiatric Issues
❍ Renal Disease
❍ Seizure Disorder
❍ Thyroid Disease

❍ OTHER: ____

Past Surgical History

Please include year surgery performed:

❍ Access Device: *(Please circle below)*
Port-A-Cath / PICC / Central Line
❍ Appendix Removal ________
❍ Bone Marrow Biopsy ________
❍ Bone Marrow Transplant ________
❍ Coronary Artery Bypass Graft _______
❍ Cataract Extraction ________
❍ Gall Bladder Removal ________
❍ Radiation Implant ________
❍ Breast Biopsy ________
❍ Colostomy Bag ________
❍ Brain Surgery ________
❍ Bladder Removal ________

❍ Gastric Volvulus ________
❍ Needle Aspiration _______
❍ Colon Resection ________
❍ Hip Surgery ________
❍ Knee Surgery ________
❍ Lumpectomy ________
❍ Lymph Node Dissection ____
❍ Kidney Removal ________
❍ Omentum Removal _______
❍ Lung Removal ________
❍ Radical Neck Dissection ____
❍ Ommaya Reservoir ________

Gender Specific:

Female:

❍ C-Section ________
❍ D and C ________
❍ Hysterectomy ________
❍ Mastectomy ________
❍ Ovary Removal ________
❍ Ovarian Cyst Removal _____

Male:

❍ Testicle Removal ________
❍ Prostate Biopsy ________
❍ Prostatectomy ________
❍ Radical Prostatectomy _____

❍ OTHER: ____

Continued on the back

Family History

Indicate illnesses in your immediate family and cancer type if applicable:

Diagnosis	Family Member	Diagnosis	Family Member
❍ Alcoholism	____________	❍ High Cholesterol	____________
❍ Alzheimer's Disease	____________	❍ Irritable Bowel Disease	____________
❍ Asthma	____________	❍ Mental Illness	____________
❍ Blood Diseases	____________	❍ Migraines	____________
❍ Coronary Artery Disease	____________	❍ Obesity	____________
❍ Cancer/type	____________	❍ Osteoarthritis	____________
❍ CVA/Stroke	____________	❍ Peripheral Vascular Disease	____________
❍ Depression	____________	❍ Renal Disease	____________
❍ Diabetes	____________	❍ Seizure Disorder	____________
❍ High Blood Pressure	____________	❍ Other	____________

Social History

Primary language spoken: ❍ English ❍ Spanish ❍ Other ____________________

Race: ❍ American Indian/Alaskan Native ❍ Asian ❍ Black/African American

❍ Native Hawaiian/Pacific Islander ❍ More than one race ❍ Other race ❍ White

Ethnicity: ❍ Hispanic or Latino ❍ Not Hispanic or Latino

Do you use tobacco? ❍ Yes ❍ No ❍ Quit/year quit ________

If you answered "Yes" or "Quit" above, what type? ❍ Chewing ❍ Cigar ❍ Cigarettes ❍ Pipe

❍ Smokeless Number of years tobacco used: ______ How much 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

Would you like to identify a religious preference? ____________________

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

List any known allergies to medications or other substances. ____________________

What type of reaction do you have? ____________________

Do you have any barriers in communication? ❍ Deaf ❍ Blind ❍ Mute

If so, do you need an interpreter? ❍ Yes ❍ No