



North Shore Oncology Hematology Associates, LTD

NEW PATIENT HISTORY FORM

(Please print. Thank you.)

Patient Name: _____ **Today's Date:** _____

DOB: ___ / ___ / ___ **Age:** _____ **Male / Female** (circle one) **SSN:** _____

Married / Single/ Divorced/ Widowed (circle one) **Spouse/Partner's Name:** _____

Address: _____ **Ph:** (____) _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____ **Cell Ph:** (____) _____

Name of Employer: _____ **Work Phone:** _____

Pharmacy / (location) : _____ **Allergies:** _____

Primary Language spoken at home: _____

Primary Care Physician : _____ **Phone #** _____

Referring Physician (if different) : _____ **Phone #** _____

Reason For Visit : _____

Emergency Contact Name: _____ **Phone :** _____ **Relationship:** _____

Power of Attorney (if applicable): _____ **Relation to You :** _____

Living Will: Yes No **Advanced Directives:** Yes No

Primary Insurance Carrier		Secondary Insurance Carrier	
Name of primary policy holder		Name of secondary policy holder	
Policy holder's Date of Birth / /	Policy holder's SSN	Policy holder's Date of Birth / /	Policy holder's SSN
Policy holder's employer		Policy holder's employer	
Policy holder's employer phone no. ()	Policy holder's employer address	Policy holder's employer phone no. ()	Policy holder's employer address
Does plan have prescription coverage? (circle) YES NO		Does plan have prescription coverage? (circle) YES NO	



North Shore Oncology Hematology Associates, LTD

NEW PATIENT HISTORY FORM

Patient Name: _____ **DOB:** _____ **Age:** _____

Primary Care Physician : _____ **Phone #** _____

Referring Physician (if different) : _____ **Phone #** _____

Reason For Visit: _____

Cancer History:

Detail any family history of cancer and/or blood disorders, including aunts, uncles, cousins, grandparents and immediate family: _____

Surgical History: (Please list all surgeries and /or procedures along with **date** of occurrence)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Medical History: (Check the items that apply to you, currently or in the past)

- | | | |
|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma / Cataracts | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Heart Attack- MI | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heartburn/ Reflux | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A/ B/ C | <input type="checkbox"/> Pneumonia/Bronchitis |
| <input type="checkbox"/> Chronic Lung (COPD) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Problems with Anesthesia |
| <input type="checkbox"/> Cirrhosis of Liver | <input type="checkbox"/> High Cholesterol/Triglycerides | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Drug Use | <input type="checkbox"/> Kidney Disease / Failure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Enlarged prostate | <input type="checkbox"/> Lupus - Autoimmune | <input type="checkbox"/> TB (Tuberculosis) |
| <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Frequent Urinary Tract Infections | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> TMJ |
| | | <input type="checkbox"/> Ulcerative Colitis |

Other Illnesses or _____

Conditions not listed : _____



North Shore Oncology Hematology Associates, LTD

NEW PATIENT HISTORY FORM

Health Maintenance Screening tests:

Sigmoidoscopy / Colonoscopy: Yes No

Findings: _____

Date performed: _____

Location performed: _____

Date due for next colonoscopy: _____

Bone density test (DEXA scan): Yes No

Any Genetic Screening : _____

Diet:

Describe any special diet you follow: _____

Glucose/ (Sugar): Yes ► Results _____ No

Immunization History : If Yes, give approximate year given

Pneumococcal: No Yes _____

Varicella (chicken pox): Vaccine or Illness : No Yes

Hepatitis A: No Yes _____

Influenza (Flu): No Yes _____

Hepatitis B: No Yes _____

H1N1: No Yes _____

Tetanus: No Yes _____

Meningitis: No Yes _____

Other:

Drug Allergies: List all medication allergies.

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Are you allergic to: (circle all that apply)

Iodine Latex Shellfish CT Scan Dye / IV Contrast Eggs Peanuts

Other: _____

Type of Reaction: _____

Please List any Additional Physicians you see: (Include Phone # and reason for visit)



North Shore Oncology Hematology Associates, LTD

NEW PATIENT HISTORY FORM

Review of Symptoms: Please check any **current** symptoms you have.

Gastrointestinal

- Poor Appetite
- Abdominal Pain
- Indigestion
- Trouble Swallowing
- Diarrhea
- Constipation
- Change in Bowel Habits
- Nausea or Vomiting
- Rectal Bleeding or Blood in Stool

Hematologic/Lymphatic

- Bleeding or bruising tendency
- Past transfusion
- Other: _____

Cardiovascular

- Chest Pain
- Irregular Heart Beat
- Leg pain with walking

Pulmonary/lungs

- Shortness of Breath
- Persistent Cough
- Coughing up Blood
- Asthma or Wheezing

Muscle/joint/bone

- Swelling of Ankles or Legs
- Pain, Weakness or Numbness in Arms/ Hands
- Back or Hips
- Legs or Feet
- Neck or Shoulders

Neurologic

- Numbness
- Weakness
- Blackouts or Loss of Consciousness
- Headaches/Migraines
- Seizures

General

- Weight gain/loss
- Poor sleep
- Fever
- Headache
- Depression

Genitourinary

- Frequent or painful urination
- Blood in urine
- Incontinence or Dribbling
- Erectile Dysfunction

Skin

- Itching
- Easy Bruising
- Change in Moles
- Varicose Veins
- Yellowing of skin/eyes

Eyes, ears, nose, throat

- Blurred Vision
- Other Changes in Vision
- Loss of Hearing
- Ringing in Ears
- Sinus Problems
- Hoarseness
- Nosebleeds

Psychiatric

- Depression
- Anxiety/ stress
- Memory loss or Confusion

Endocrine

- Excessive Urination
- Excessive Thirst
- Change in Tolerance to Hot or Cold Weather
- Abnormal hair growth or loss

Other: _____

- In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless?
- Are there any specific personal issues you would like to bring up at the time of your visit?

**** I attest that the above information is true and correct to the best of my belief.**

Patient Signature: _____ Date: _____

Physician Signature/Initial _____ Date: _____

