

NORTH SHORE ONCOLOGY - HEMATOLOGY

NEW PATIENT HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Male / Female (circle one)

Power of Attorney (if applicable): _____

Relation to you : _____

Primary Care Physician : _____

Referring Physician (if different) : _____

Reason for visit: _____

The following information is very important to your health. Please take the time to fully & accurately fill out this form.

MEDICAL HISTORY: (Circle items that apply to you, currently or in the past)

Cancer (specify type & give details of diagnosis & treatment) _____

Surgery (specify) _____

- | | | | |
|--|------------------------|----------------------------------|--------------------|
| Frequent Infections | High Blood Pressure | Kidney Disease | Heart Disease |
| Heart Murmur | Blood Clots | Blood Transfusions | Asthma |
| Drug Use | Arthritis | Bleeding disorder | HIV/Hepatitis |
| Liver Disease | Seizures | Heavy/Irregular Menses | Lung Disease |
| Thyroid Disease | Ulcers | Bowel Disorder | Hypertension |
| Anemia | High Cholesterol | Peripheral Vascular Disease | Emphysema |
| Bronchitis | Heartburn | Peptic Ulcer Disease | Colon Polyps |
| Enlarged Prostate | Kidney Stones | Macular Degeneration | Hearing Loss |
| Neuropathy | Lupus | Uterine Fibroids | Abnormal Pap Smear |
| Rheumatoid Arthritis | Degenerative Arthritis | Low Blood Counts | Glaucoma |
| Migraines | Stroke | Cataracts | |
| Transient Ischemic Attack (TIA) | | Other Connective Tissue Disorder | |
| Chronic Obstructive Pulmonary Disease (COPD) | Diabetes | Date of Onset: _____ | |

NORTH SHORE ONCOLOGY - HEMATOLOGY

NEW PATIENT HISTORY FORM

CURRENT MEDICATIONS:

	Name	Dose	How often
Prescription Medications:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Over the counter medications: (If more space is needed, continue on the back of this page)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

DRUG ALLERGIES:

List all known drug allergies and reactions:

Are you allergic to: (circle all that apply) Iodine Shellfish CT Scan Dye / IV Contrast

FAMILY HISTORY:

Indicate cause of death or medical problems as appropriate

Father: Age _____ Living/Deceased _____

Mother: Age _____ Living/Deceased _____

Bro/Sis: Age _____ Living/Deceased _____

Bro/Sis: Age _____ Living/Deceased _____

Bro/Sis: Age _____ Living/Deceased _____

Bro/Sis: Age _____ Living/Deceased _____

Bro/Sis: Age _____ Living/Deceased _____

Bro/Sis: Age _____ Living/Deceased _____

NORTH SHORE ONCOLOGY - HEMATOLOGY

NEW PATIENT HISTORY FORM

GYNECOLOGICAL HISTORY (CONTINUED):

Hysterectomy / Removal of Uterus: Yes / No If yes, date: _____
If yes, did this include removal of ovaries? Yes / No

Name of OB/GYN Physician: _____ Phone _____

Date of last Pelvic Exam: _____

Date of last Mammogram: _____ Where Performed: _____

SCREENING TESTS:

Bone density test (DEXA scan) Yes / No Date performed: _____

Location performed: _____

Colonoscopy Yes / No Findings: _____

Location Performed: _____

Date due for next colonoscopy: _____

DIET:

Describe any special diet you follow: _____

ADDITIONAL COMMENTS:

ANY HISTORY OF THE FOLLOWING – Circle all that apply and explain:

- Fever _____
- Fatigue _____
- Weight Loss or Gain _____
- Rashes _____
- Night Sweats _____
- Itching _____
- Recurrent Headaches _____
- Recent Change in Vision _____
- Change in Hearing _____
- Sore Throat _____
- Muscle Pain _____
- Bone / Joint Pain _____
- Joint Swelling _____
- Joint Stiffness _____

NORTH SHORE ONCOLOGY - HEMATOLOGY

NEW PATIENT HISTORY FORM

(continued from page 4)

- Cough _____
- Phlegm Production _____
- Shortness of Breath _____
- Wheezing _____
- Chest Pain _____
- Palpitations _____
- Abdominal Pain _____
- Nausea / Vomiting _____
- Change in Bowel Habits _____
- Blood in Stool _____
- Black Stools _____
- Constipation _____
- Diarrhea _____
- Heartburn _____
- Leg / Ankle Swelling _____
- Urinary Hesitancy _____
- Difficulty in Urination _____
- Urinary Dribbling _____
- Urinary Burning/Pain _____
- Blood in Urine _____
- Loss of Bladder/Bowel Control _____
- Numbness/Tingling _____
- Seizures _____
- Fainting Spells _____
- Weakness in any part of body _____
- Confusion _____
- Decreased Memory _____
- Depression _____
- HIV Risk Factors _____
- Easy Bruising _____
- Nasal Bleeding _____

Other Illnesses or
Conditions not listed _____

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

Patient signature: _____