Hematology Oncology Associate of Central New York

Medical History

Name: _____ **Date**: _____

□ Male □ Female

DOB: _____ **Age**: _____

Reason for referral to our office: _____

Primary Care Doctor: _____

Other Physicians: _____

Dentist: _____

What pharmacy do you use? _____Phone:_____

Are you allergic to IV contrast? □Yes □No

Do you have any allergies? Please list:

Allergen:	**(food/drug/latex/environmental?)**	**Reaction**

Medical History:

Have you been diagnosed with any of the following conditions?

□Yes □No Cancer If yes, type: _____, treatment received_____

□Yes □No Heart problems if yes, describe: _____

□Yes □No High blood pressure

□Yes □No Blood Clot

□Yes □No GERD or Gastric Reflux

□Yes □No High Cholesterol

□Yes □No Asthma

□Yes □No Emphysema/COPD

□Yes □No Thyroid problems If yes, describe: _____

□Yes □No Diabetes (E10.09, E11.9)

□Yes □No Multiple Sclerosis (MS)

□Yes □No Rheumatoid Arthritis

□Yes □No Other Arthritis If yes, describe: _____

□Yes □No Depression

□Yes □No Anxiety

□Yes □No Hepatitis

□Yes □No Tuberculosis

□Yes □No Stroke

□Yes □No Kidney Disease If yes, describe: _____

□Yes □No Anemia

□Yes □No Epilepsy/Seizure

□Yes □No Alcoholism or Chemical Dependency

□Yes □No Other Medical Problems _____

□ Yes □No Hearing Problems If yes, do you wear a hearing aid? □ Yes □ No

Name of Patient: **DOB:**

Surgical History & Hospitalizations

Month/Year:	Surgery/Reason for Hospitalization:
_____	_____
_____	_____
_____	_____
_____	_____

Personal Health Screening

Colonoscopy ☐Yes ☐No Date of last exam _____
Mammogram ☐Yes ☐No Date of last exam _____
Bone Density ☐Yes ☐No Date of last exam _____

Female's Only – Gyn/Breast History

What age did you have your first period? _____
How many times have you been pregnant? _____
How many children have you given birth to? _____
Did you breast feed? ☐Yes ☐No
Did you ever take oral contraceptives for birth control? ☐Yes ☐No
If yes, at what age & how long? _____
Have you experienced menopause? ☐Yes ☐No
If yes, at what age? _____
If no, do you have regular periods? _____
What is the date of your last period? _____
What is the date of your last pap smear? _____
Have you ever taken hormone replacement therapy (estrogen or progesterone)? ☐Yes ☐No
If yes, at what age did you begin? _____ for how many years? _____

Immunizations

Month and Year of last Influenza immunization_____
Month and Year of Pneumococcal immunization_____
Month and Year of Shingles vaccination _____
Covid vaccine #1 Type date
Covid vaccine #2
Covid booster Type date

Current Medications (Please include over the counter medications, vitamins and supplements)

Name of Drug	Dose	How Often Do You Take This Medicine	Prescriber	Medication is for

Name of Patient: **DOB:**

Family History:

Ethnicity: Ashkenazi Jewish ☐Yes ☐ No
(for genetic history purposes only)

Family Cancer history: (if unsure of age at diagnosis, estimate >50 or <50)

Mother: Type of cancer _____ Age at diagnosis _____

Father: Type of cancer _____ Age at diagnosis _____

Sister: Type of cancer _____ Age at diagnosis _____

Brother: Type of cancer _____ Age at diagnosis _____

Maternal Grandmother: Type of cancer _____ Age at diagnosis _____

Maternal Grandfather: Type of cancer _____ Age at diagnosis _____

Paternal Grandmother: Type of cancer _____ Age at diagnosis _____

Paternal Grandfather: Type of cancer _____ Age at diagnosis _____

Daughter: Type of cancer _____ Age at diagnosis _____

Son: Type of cancer _____ Age at diagnosis _____

Other Family Member: Type of cancer _____ Age at diagnosis _____

Family Hematologic History:

Mother: Myocardial Infarction ☐Yes ☐No
Stroke ☐Yes ☐No
Clotting Problems ☐Yes ☐No
Anemia ☐Yes ☐No
If yes to any, please describe:

Father: Myocardial Infarction ☐Yes ☐No
Stroke ☐Yes ☐No
Clotting Problems ☐Yes ☐No
Anemia ☐Yes ☐No
If yes to any, please describe:

Sister: Myocardial Infarction ☐Yes ☐No
Stroke ☐Yes ☐No
Clotting Problems ☐Yes ☐No
Anemia ☐Yes ☐No
If yes to any, please describe:

Brother: Myocardial Infarction ☐Yes ☐No
Stroke ☐Yes ☐No
Clotting Problems ☐Yes ☐No
Anemia ☐Yes ☐No
If yes to any, please describe:

Name of Patient: **DOB:**

Maternal Grandmother: Myocardial Infarction ☐Yes ☐No
Stroke ☐Yes ☐No
Clotting Problems ☐Yes ☐No
Anemia ☐Yes ☐No
If yes to any, please describe:

Maternal Grandfather: Myocardial Infarction ☐Yes ☐No
Stroke ☐Yes ☐No
Clotting Problems ☐Yes ☐No
Anemia ☐Yes ☐No
If yes to any, please describe:

Paternal Grandmother: Myocardial Infarction ☐Yes ☐No
Stroke ☐Yes ☐No
Clotting Problems ☐Yes ☐No
Anemia ☐Yes ☐No
If yes to any, please describe:

Paternal Grandfather: Myocardial Infarction ☐Yes ☐No
Stroke ☐Yes ☐No
Clotting Problems ☐Yes ☐No
Anemia ☐Yes ☐No
If yes to any, please describe:

Daughter: Myocardial Infarction ☐Yes ☐No
Stroke ☐Yes ☐No
Clotting Problems ☐Yes ☐No
Anemia ☐Yes ☐No
If yes to any, please describe:

Son: Myocardial Infarction ☐Yes ☐No
Stroke ☐Yes ☐No
Clotting Problems ☐Yes ☐No
Anemia ☐Yes ☐No
If yes to any, please describe:

Other Family Member:
Myocardial Infarction ☐Yes ☐No
Stroke ☐Yes ☐No
Clotting Problems ☐Yes ☐No
Anemia ☐Yes ☐No
If yes to any, please describe:

Social History:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Living Arrangement:
☐ Lives with spouse ☐ alone ☐ with children ☐ with relatives ☐ care facility ☐ Other_____

Do you have children? ☐ Yes ☐ No

Occupation:
☐ Primary Occupation _____ ☐ Full time ☐ Part time
☐ Secondary Occupation _____ ☐ Full time ☐ Part time
☐ Retired, previous occupation _____
☐ Disabled: ☐ short term ☐ long term ☐ Intermittent (FMLA)

Name of Patient: **DOB:**

Alcohol use:

□ Never □ Social □ Currently uses

drinks per week _____

□ Stopped alcohol use (year) _____

Recreational drug use: □ Yes □ No

If yes, please describe _____

Smoking History

□ Non smoker

□ Never smoker □ Former smoker

□ Current smoker

□ Daily tobacco smoker □ Occasional tobacco smoker

□ Pipe smoker □ smokeless tobacco (type _____) □ Electronic cigarette user

□ Exposed to tobacco smoke at home

□ Exposed to tobacco smoke at work

□ No know tobacco smoke exposure

Started smoking at age _____

Quit smoking at age _____

Packs per day _____

Interested in smoking cessation □ Yes □ No