NORTHERN MICHIGAN HEMATOLOGY/ONCOLOGY

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	DOB	SOCIAL SECURITY #

STREET ADDRESS: (Not P.O. Box)	CITY, STATE	ZIP CODE

PLACE OF BIRTH	HOME TELEPHONE	CELL	OTHER

E-MAIL ADDRESS	NEXT OF KIN AND CONTACT NUMBER

SEX	MARITAL STATUS	EMERGENCY CONTACT: NAME/TELEPHONE #
□ M □ F	□ MARRIED □ PARTNERED □ DIVORCED □ WIDOWED □ SINGLE	

PRIMARY CARE PHYSICIAN (required)	TELPHONE	RELIGIOUS DENOMINATION

EMPLOYER INFORMATION □ Retired □ Unemployed □ Disabled □ Other: _____

EMPLOYER NAME	EMPLOYER PHONE NUMBER

STREET ADDRESS (Not P.O. Box)	CITY, STATE	ZIP CODE

HEALTH HISTORY

Main reason for today's visit: _____

PAST MEDICAL PROBLEMS

Lung disease or emphysema	□ Yes □ No	Hepatitis or Jaundice	□ Yes □ No
High blood pressure	□ Yes □ No	Kidney disease	□ Yes □ No
Heart failure	□ Yes □ No	Digestive problems	□ Yes □ No
Previous heart attack	□ Yes □ No	Gynecological problems	□ Yes □ No
Diabetes	□ Yes □ No	Ulcers	□ Yes □ No

Previous cancer □ Yes □ No **If yes, explain below**

_____

_____

OTHER MEDICAL PROBLEMS

_____

_____

_____

_____

_____

PAST SURGERIES List any surgeries that you have had and the date of the surgery (month/year)

_____

_____

_____

CURRENT MEDICATIONS
List all prescription medications, including dose, and how many times per day each medicine is taken.
Bring all medications with you to your initial appointment.

_____

_____

_____

_____

_____

_____

List all **over-the-counter medications**, **supplements**, or **herbal medicines** that you are taking.

_____

_____

ALLERGIES List and describe any allergies to medicines or other substances (such as IV contrast, foods)

_____

_____

_____

PERSONAL HISTORY

Have you served in the Armed Forces? □ Yes □ No If yes, list details: _____

Do you smoke? □ Yes □ No If yes, how many per day? _____ cigarettes _____ cigars _____ pipe

Have you ever smoked? □ Yes □ No If yes, how long did you smoke? _____ When did you quit? _____

Do you drink alcoholic beverages? □ Yes □ No If yes, how many drinks per day? _____

Has drinking ever been a problem for you? □ Yes □ No

Have you ever felt you should "cut-down" on your drinking? □ Yes □ No

Have you ever had a drug problem or are you using drugs now? □ Yes □ No

FOR WOMEN ONLY

Have you gone through menopause? □ Yes □ No If yes, list date of last menstrual period: _____

List your age at time of first menstrual period: _____ List number of pregnancies: _____ Age at first pregnancy: _____

Have you been treated with hormone replacement therapy? □ Yes □ No If yes, list dates of treatment: _____

HEALTH SCREENING / HEALTH MAINTENANCE

Have you ever been checked for colon cancer? □ Yes □ No

If yes, which test? □ Colonoscopy Date _____ □ Sigmoidoscopy Date_____ □ Other: _____Date: _____

If applicable, have you ever had a mammogram? □ Yes □ No If yes, date of last mammogram: _____

If applicable, have you ever had a test for prostate cancer? □ Yes □ No If yes, date of test: _____

FAMILY HISTORY

Are your parents living? □ Yes □ No
If yes, list current age and any health problems. If no, list the age at death and cause of death.

Mother_____ Father_____

Do you have brothers/sisters? □ Yes □ No If yes, list their age and any health problems:

_____

_____

Do you have children? □ Yes □ No Ages: _____

PERSONAL RESOURCES AVAILABLE: Would you like to see any of the following resource persons: Check all that apply

□ Social Worker □ Nutrition Counselor □ Financial Advisor □ Spiritual Care

REVIEW OF SYSTEMS Check any current symptoms that you have.

Constitutional
□ Recent fevers/sweats
□ Unexplained weight loss/gain
□ Unexplained weakness/fatigue

Eyes
□ Change in vision
□ Double vision
□ Eye pain

Ear/Nose/Throat/Mouth
□ Difficulty hearing/ringing in ears
□ Trouble swallowing
□ Mouth sores

Cardiovascular
□ Chest pain
□ Palpitations
□ Shortness of breath with exertion

Musculoskeletal
□ Muscle/joint pain
□ Recent back pain

Respiratory
□ Cough/wheeze
□ Coughing up blood
□ Shortness of breath

Gastrointestinal
□ Heartburn/reflux
□ Blood in bowel movement
□ Nausea/vomiting/diarrhea

Genitourinary
□ Painful/bloody urination
□ Leaking urine
□ Unusual vaginal bleeding

Blood/Lymphatic
□ Unexplained lumps
□ Easy bleeding/bruising

Endocrine
□ Cold/heat intolerance
□ Increased thirst/appetite

Skin
□ Rash
□ New or change in mole

Neurological
□ Headaches
□ Memory loss
□ Numbness or tingling

Psychiatric
□ Anxiety/stress
□ Sleep problems
□ Loss of interest in activities
□ Feeling down, depressed or hopeless

Breast
□ Breast lump
□ Nipple discharge

Pain
□ Yes If yes, how severe on a scale of 1-10 ____
(10 being the worst pain)
Where is the pain located_____
□ No

Patient Signature _____ Date_____