

Lake Shore Oncology/Hematology Patient History Form

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

Power of Attorney (if applicable): _____
Relation to you: _____

Primary Care Physician: _____
Referring Physician: _____
Reason for visit: _____

Medical History:

Cancer type, details of diagnosis & treatment: _____

Surgery: _____

High Blood Pressure	Anemia	Arthritis	HIV/Hepatitis
High Cholesterol	Blood Transfusion	Rheumatoid Arthritis	Migraines
Heart Disease	Bleeding Disorder	Degenerative Arthritis	Seizures
Heart Murmur	Rashes	Connective Tissue Disorder	Hearing Loss
Diabetes	Easy Bruising	Lupus	Neuropathy
Lung Disease	Gum Bleeding	Drug Use	Peptic Ulcer Disease
Asthma	Nose Bleeds	Kidney Stones	
COPD/ Emphysema	Uterine Fibroids	Heartburn	
Bronchitis	Low Blood Counts	Bowel Disorder	
Liver Disease	Frequent Infections	Colon Polyps	
Thyroid Disease	Blood Clots	Glaucoma	
Kidney Disease	Stroke	Macular Degeneration	
Enlarged Prostate	TIA	Cataracts	

Lake Shore Oncology/Hematology

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 _____

Lake Shore Oncology/Hematology

Children:

Age _____	Gender M/F _____	Health Status _____
Age _____	Gender M/F _____	Health Status _____
Age _____	Gender M/F _____	Health Status _____
Age _____	Gender M/F _____	Health Status _____
Age _____	Gender M/F _____	Health Status _____

Cancer History:

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

Social History: (Circle items that apply to you)

Marital Status:	Single	Married	Separated	Divorced	Widowed
Alcohol use:	Never	Rarely	Moderate	Daily (Indicate amount per day) _____	
Tobacco use:	Never	Quit: Year quit _____		Current Smoker: Packs per day _____	
		Packs per day _____			
		Years as a smoker _____			
Drug / IV Drug use:	Never	Type/Frequencies _____			
History of exposure to:	Asbestos	Fumes	Solvents	Dust/Air born particles	
	Chemicals	Radiation			
	Explain any exposure: _____				

Occupation: _____

Gynecological History:

Menstrual History	Age at start of menstrual cycle	_____
	Date of last menstrual period	_____
	Frequency of menstruation	_____
	Duration of menstruation	_____
	Age of first pregnancy	_____
	Did you Breast-feed?	_____
	Age of Menopause	_____
	History of contraceptive use	_____
	Duration (roughly):	_____
Hormone replacement therapy:	Yes /No	Duration of Therapy: _____

Lake Shore Oncology/Hematology

Gynecological History (continued):

Hysterectomy / Removal of Uterus: Yes / No If yes, date: _____ Why? _____
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: _____ Date Performed: _____ 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 please explain:

Fever	_____
Night Sweats	_____
Fatigue	_____
Weight Loss or Gain	_____
Rashes	_____
Itching	_____
Chest Pain	_____
Shortness of Breath	_____
Palpitations	_____
Irregular Heart Beat	_____
Leg / Ankle Swelling	_____
Cough	_____

Lake Shore Oncology/Hematology

Phlegm Production	_____
Wheezing	_____
Heartburn / Reflux	_____
Abdominal Pain	_____
Nausea / Vomiting	_____
Change in Bowel Habits	_____
Constipation	_____
Diarrhea	_____
Blood in Stools	_____
Black Stools	_____
Blood in Urine	_____
Urinary Burning	_____
Urinary Dribbling	_____
Difficulty in Urination	_____
Urinary Hesitancy	_____
Loss of Bladder / Bowl Control	_____
Recurrent Headaches	_____
Recent Change in Vision	_____
Change in Hearing	_____
Numbness / Tingling	_____
Seizures	_____
Fainting Spells	_____
Confusion	_____
Decreased Memory	_____
Weakness in any part of body	_____
Depression	_____
Anxiety	_____
HIV Risk Factors	_____
Muscle Pain	_____
Bone / Joint Pain	_____
Sore Throat	_____
Pain (specify)	_____
Easy Bruising	_____
Nasal Bleeding	_____
New Skin Lesion	_____
Other Illnesses or Conditions not listed	_____

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

Patient signature: _____

