



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:** _____

Preferred Language: _____ **Ethnicity/Race:** American Indian/Alaska Native White
 Native Hawaiian/Other Pacific Islander Asian
 Black/African American Other

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	



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

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

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

Reason For Visit: _____

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"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma / Cataracts | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Heart Attack- MI | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heartburn/ Reflux | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pneumonia/Bronchitis |
| <input type="checkbox"/> Chronic Lung (COPD) | <input type="checkbox"/> Hepatitis A/ B/ C | <input type="checkbox"/> Problems with Anesthesia |
| <input type="checkbox"/> Cirrhosis of Liver | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Reynaud's Syndrome |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> High Cholesterol/Triglycerides | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <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"/> Osteoarthritis | <input type="checkbox"/> Ulcerative Colitis |

Details of Medical History: _____

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

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



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Drug Allergies: List all medication allergies.

** See Attached Medication List**

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: _____

Family History:

Father: Alive Deceased Age and Cause of Death: _____
Mother: Alive Deceased Age and Cause of Death: _____
Brothers: Total Number _____ Alive Deceased Age and Cause of Death: _____
Sisters: Total Number _____ Alive Deceased Age and Cause of Death: _____
Children: Total Number _____
 Age: _____ Male Female Health Issues: _____
 Age: _____ Male Female Health Issues: _____
 Age: _____ Male Female Health Issues: _____
 Age: _____ Male Female Health Issues: _____

In your opinion, are there any diseases that run in your family? No Yes

▶ Please list: _____

Cancer History:

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

Social History:

Married / Single/ Divorced/ Widowed (circle one)

Education (Years/Degrees) _____ Occupation _____

Exercise: Yes ▶ Type & Frequency: _____ No

Tobacco use: (Present &/or Past) - smoked or chewed tobacco? No Yes ▶ How much? ____/ day

How many years? _____ Did you quit? Yes ▶ When: _____ No ****

*****(Information per office policy provided)

Alcohol use: (Present &/or Past use) None Yes ▶ How much? (oz) _____ / day week month

Drug/ IV Drug use: _____

History of exposure to: Asbestos Fumes Solvents Dust/Air particles Chemicals Radiation

Explain any exposure: _____



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Reproductive History:

FEMALE:

Name of OB/GYN Physician: _____ Phone _____

Menstrual History:

Age when menstrual cycle started _____
Date of Last menstrual cycle : _____ Frequency: _____
Age at first childbirth _____
Age at menopause _____
History of contraceptive use: (Type) _____ Duration of use _____
Hormonal Replacement Therapy: No Yes ► Type: _____ Duration of use _____
Hysterectomy / Removal of Uterus: No Yes ► date: _____

• **If yes**, did this include removal of ovaries: Yes No

Last PAP smear: _____ Last mammogram: _____ Last Dexa Scan _____ Where performed: _____

MALE:

Hernias: Yes No Testicular pain: Yes No Testicular swelling: Yes No
* PSA Test: Yes No Result: _____

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? : _____
Vitamin D Level: Yes No

Diet:

Describe any special diet you follow: _____

Glucose/ (Sugar) Level: Yes ► Results _____ No

Immunization History : If Yes, give approximate year given

Pneumococcal: No Yes _____
Hepatitis A: No Yes _____
Hepatitis B: No Yes _____
Tetanus: No Yes _____
Varicella (chicken pox): Vaccine or Illness : No Yes _____
Influenza (Flu): No Yes _____
H1N1: No Yes _____
Meningitis: No Yes _____

Other:

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



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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: _____

