



# 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:** \_\_\_\_\_

**Primary Language spoken at home:** \_\_\_\_\_

**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

<b>Primary Insurance Carrier</b>		<b>Secondary Insurance Carrier</b>	
<b>Name of primary policy holder</b>		<b>Name of secondary policy holder</b>	
<b>Policy holder's Date of Birth</b> / /	<b>Policy holder's SSN</b>	<b>Policy holder's Date of Birth</b> / /	<b>Policy holder's SSN</b>
<b>Policy holder's employer</b>		<b>Policy holder's employer</b>	
<b>Policy holder's employer phone no.</b> ( )	<b>Policy holder's employer address</b>	<b>Policy holder's employer phone no.</b> ( )	<b>Policy holder's employer address</b>
<b>Does plan have prescription coverage? (circle)</b> YES      NO		<b>Does plan have prescription coverage? (circle)</b> YES      NO	



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**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Primary Care Physician :** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Referring Physician (if different) :** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Reason For Visit:** \_\_\_\_\_

### **Cancer History:**

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

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

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

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

**Other Illnesses or** \_\_\_\_\_

**Conditions not listed :** \_\_\_\_\_



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### **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: \_\_\_\_\_  
\_\_\_\_\_

### **Reproductive History:**

#### **FEMALE:**

Name of OB/GYN Physician: \_\_\_\_\_ Phone \_\_\_\_\_

#### **Menstrual History:**

Age 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

Sexually active:  Yes  No

Last PAP smear \_\_\_\_\_ Last mammogram: \_\_\_\_\_ Where Performed: \_\_\_\_\_

#### **MALE:**

Hernias:  Yes  No Testicular pain:  Yes  No PSA Test:  Yes  No  
Testicular swelling:  Yes  No Sexually active:  Yes  No Result: \_\_\_\_\_

### **Social History:**

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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### **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 : \_\_\_\_\_

### **Diet:**

Describe any special diet you follow: \_\_\_\_\_

Glucose/ (Sugar):  Yes ► Results \_\_\_\_\_  No

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### **Immunization History :** If Yes, give approximate year given

Pneumococcal:  No  Yes \_\_\_\_\_

Varicella (chicken pox): Vaccine or Illness :  No  Yes \_\_\_\_\_

Hepatitis A:  No  Yes \_\_\_\_\_

Influenza (Flu):  No  Yes \_\_\_\_\_

Hepatitis B:  No  Yes \_\_\_\_\_

H1N1:  No  Yes \_\_\_\_\_

Tetanus:  No  Yes \_\_\_\_\_

Meningitis:  No  Yes \_\_\_\_\_

### **Other:**

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### **Drug Allergies:** List all medication allergies.

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

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: \_\_\_\_\_

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### **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: \_\_\_\_\_

