

MATTHEWS HEMATOLOGY ONCOLOGY ASSOCIATES

PATIENT NAME: _____

CHIEF COMPLAINT: Why have you been referred to our office? _____

REFERRING DOCTOR: _____

PRIMARY DOCTOR: _____

PREFERRED PHARMACY: _____

PHONE #: _____

ADDRESS: _____

MEDICATIONS: Please list *all* the medications you are taking. Please include the dosage and frequency.

DRUG ALLERGIES: Please list and include reactions (rash, hives, breathing problems, etc.)

Check if you have an allergy to IV/Iodine contrast used in radiology procedures.

MEDICAL ILLNESSES: Please check all that apply.

NERVOUS SYSTEM

- Stroke / TIA
- Seizures
- Severe anxiety
- Depression

BONES / JOINTS

- Arthritis
- DJD
- Rheumatoid
- Fractures

SENSES

- Hearing loss / deafness
- Vision loss / blindness
- Glaucoma / cataracts

ENDOCRINE

- Diabetes
- Thyroid- High Low

CARDIOVASCULAR

- High blood pressure
- Angina, heart attack
- Congestive heart failure
- Abnormal heart rhythm

INFECTIONS

- HIV / AIDS
- Hepatitis

LUNGS

- Asthma
- Emphysema / COPD

KIDNEYS

- Kidney failure
- Kidney stones

GASTROINTESTINAL

- Ulcers, reflux, gastritis
- Colitis / diarrhea
- Liver disease

BLOOD DISORDERS

- Anemia
- Abnormal blood counts
- Clotting problems

CANCER

Current diagnosis (what type):

 Previous diagnosis (when, what type): _____

****Please continue to page two!****

OTHER ILLNESSES: _____

SURGICAL PROCEDURES: Please list type and date of all surgeries:

FAMILY HISTORY: If any family member has had cancer, please note what type and their relationship to you.

SOCIAL HISTORY:

Married Yes No Divorced Yes No
Widow(er) Yes No Separated Yes No

Who lives with you? _____

Cigarettes:

Have you been a smoker? Yes No

If "Yes", when did you start? _____

Have you stopped smoking Yes No

If "Yes", when did you stop? _____

Other Tobacco: Pipe Cigars Snuff Chewing tobacco

Alcohol Use: Yes No If yes, how many drinks per week? _____

Illegal Drugs: Yes No If yes, explain. _____

Occupation: _____

SYMPTOMS:	Currently	In the Past		Currently	In the Past
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising / bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty emptying bladder	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>

Weight loss: How much in the last 6 months? _____

Pain; Describe location, intensity and what makes it worse or better: _____

Please describe any other important symptoms: _____
