Medical Record #____________

HEMATOLOGY & ONCOLOGY ASSOCIATES OF NORTHEASTERN PA, PC

Name____ Date of birth ____________

What is the reason for today's visit? ____

What do you hope to accomplish at today's visit? ______________________________________

Referring Physician ______________________________________ Visit Date ____________

Primary care physician ___________________________________ Visit Date ____________

Pharmacy ____

Race ________________ Ethnicity ____________________ Language _________________

Do you have an advanced directive (Living Will) or Healthcare Power of Attorney? ____ Yes ____ No
If so, please bring a copy to the office.

Personal Past Medical History – Do you have any history of:
(Please indicate all conditions present and month/year diagnosed)

	Present	Month/Year
Acid Reflux (GERD)	__________	__________
Alcohol Abuse	__________	__________
Anemia	__________	__________
Type _______________________________		
Angina	__________	__________
Anxiety	__________	__________
Bladder Infections (UTI)	__________	__________
Bleeding Disorder	__________	__________
Specify _____________________________		
Blood Disorder	__________	__________
Specify_____________________________		
Low Blood Counts	__________	__________
High Blood Counts	__________	__________
Blood Transfusions	__________	__________
Why? _______________________________		
Cancer	__________	__________
Specify Type _________________________		
Cardiac Arrhythmias	__________	__________
Colonic Polyps	__________	__________
Colonic Tumors	__________	__________
Congestive Heart Disease	__________	__________
Coronary Artery Disease	__________	__________
Crohn's Disease	__________	__________

	Present	Month/Year
CVA (Stroke)	__________	__________
Degenerative Joint Disease (DJD)	______	__________
Depression	__________	__________
Diabetes (Type I or Type II)	__________	__________
Associated Kidney Disease	____	__________
Associated Eye Disease	______	__________
Associated Neuropathy	______	__________
Diverticulitis	__________	__________
Diverticulosis	__________	__________
DVT/Deep Vein Thrombosis (Blood Clot)	__________	
Location - ____________________________		
Eye Disease (Please Specify)	_________	__________
Glaucoma	__________	__________
Macular Degeneration	_______	__________
Retinal Tear	__________	__________
Other (Specify) _______________________		
Gallbladder Disease (Gallstones)	______	__________
Goiter	__________	__________
Gout	__________	__________

	Present	Month/Year
Grave's Disease	__________	__________
Headaches (Please specify)	__________	__________
Tension	______	__________

Migraine ______ __________
Cluster ______ __________
Other/Unknown ______ __________
Heart Murmur __________ __________
Hepatitis (Type - ______) __________ __________
Hereditary Defect __________ __________
Specify______________________________
Hiatal Hernia __________ __________
HIV/AIDS __________ __________
Hyperlipidemia (High Cholesterol) _____ __________
Hypertension (High Blood Pressure) ____ __________
Hyperthyroid (High Thyroid) _________ __________
Hypothyroid (Low Thyroid) __________ __________
Inflammatory Bowel Disease _________ __________
Irritable Bowel Syndrome __________ __________
Jaundice __________ __________
Liver Disease (example: Cirrhosis) ____ __________
Specify______________________________
Lung Disease - Asthma __________ __________
COPD __________ __________
Emphysema _______ __________
Myocardial Infarction (Heart Attack) ______ ________
Neuropathy __________ __________
Osteoarthritis __________ __________
Osteoporosis __________ __________
Osteopenia __________ __________
Pancreatitis __________ __________
Peptic Ulcer Disease __________ __________
Peripheral Vascular Disease __________ __________
Psychiatric Disease __________ __________
Specify ______________________________

Present Month/Year

Pulmonary Embolism __________ __________
(Blood Clot Lung)
Rheumatic Fever __________ __________

Present Month/Year

Renal Failure (Kidney Failure) ________ __________
Cause ______________________________
Renal Stones (Kidney Stones) _________ __________

Renal Disease Other (Kidney Disease) ____________
Specify______________________________
Seizure Disorder __________ __________
Sexually Transmitted Disease ________ __________
Skin Disorder (Specify) __________ __________
Acne/Rosacea ______ __________
Eczema ______ __________
Psoriasis ______ __________
Other (Specify) ______ __________
TIA (Mini Stroke) __________ __________
Trauma/Fracture __________ __________
Specify_______________________________
Tuberculosis __________ __________
Exposure to Tuberculosis only____________
Other medical condition not listed here:
____
____
____
____
____

Previous Surgeries

Month/Year

Amputation _________ ___________
Specify______________________________
Appendectomy _________ ___________
Arthroscopic Surgery _________ ___________
Specify______________________________
Bone Marrow Biopsy _________ ___________
Location ____________________________
Bone Marrow Transplant _________ ___________
Location ____________________________
Biopsy _________ ___________
(Specify Breast, skin, etc.)____________________
Bronchoscopy _________ ___________
Cataract Surgery – Left eye _______ Right eye_______
Cholecystectomy (gallbladder) ________ ___________
Colon Resection _________ ___________
Colonoscopy _________ ___________

Location ______________________________
Colposcopy _________ ___________
Cystectomy (cyst removal) _________ ___________
Cystoscopy _________ ___________
C-section _________ ___________
Coronary artery bypass _________ ___________
Dental Extraction _________ ___________
G/PEG-tube placement _________ ___________
Hernia Repair _________ ___________
Hickman Catheter _________ ___________
Hysterectomy (total/partial) _________ ___________
IVC Filter _________ ___________
Lung(or pulmonary)resection_________ ___________
Mastectomy (Left/right) _________ ___________
Melanoma Removal _________ ___________
Orthopedic Surgery _________ ___________
Specify_______________________________
Ovarian Tumor Removal _________ ___________
Paracentesis (abdominal fluid) _________ ___________
Partial Mastectomy _________ ___________
Left/Right breast _____________
Plastic Surgery _________ ___________
Specify______________________________________
Port-a-Cath placement/removal ________ ___________
Location ____________________________
Prostate Gland Removal _________ ___________
Stent Placement _________ ___________
Location _______________________________
Thoracentesis (lung fluid) _________ ___________
Tonsillectomy _________ ___________
Total Hip Replacement _________ ___________
Left/Right ______________________________

Total Knee Replacement _________ ___________
Left/Right______________________________
Tubal Ligation _________ ___________

TURP (resection of prostate) _________ ___________
Vasectomy _________ ___________
Other surgeries or procedures and hospitalizations with the dates:

____
____
____
____
____
____
____
____
____
____

Women:

Age of first menstrual period _______
Age of first live birth _______
Date of last menstrual period _______
Menstrual period length _______
Number of pregnancies _______
Number of live births _______
Number of miscarriages _______
Date/Age of menopause _______
Any hormonal supplement/birth control use?
____Yes ____No
Specify type/length of use
____
Date of last pap smear (Mo/Day/Yr) ___________
Date of last mammogram (Mo/Day/Yr) ________
Date of last Dexa scan (Mo/Day/Yr) ________

Male:

Testicular Disease(specify)_____________________
Prostate Disease(specify)______________________
Last PSA (Mo/Day/Yr) ________
Last prostate exam (Mo/Day/Yr) ________

Do you have any medical problems that you believe may limit your life to less than 1 year?

____
____
Rate your quality of life. **0 is the worst** and **10 is the best.** 0 1 2 3 4 5 6 7 8 9 10
Do you have regular pain? Yes No
If yes, where is your pain?
____

Family History: Please fill out as much information as possible.

Family Member	Sex	Disease(s)	Age	If deceased, cause & age of death
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Father				
Mother				
Siblings 1.				
2.				
3.				
4.				
5.				
6.				
Children 1.				
2.				
3.				
4.				
5.				

Social History:
Do you use tobacco? ___ Yes ___ No If so, what kind (cigarettes, cigars, etc.):
How many years: _____________ How many packs per day? ______
If you do not currently use tobacco, have you ever smoked? _ Yes _ No When did you quit smoking? ___________
How many years: ________ How many packs per day? __________ Does anyone in your home smoke? _ Yes _ No
Do you drink alcohol? _ Yes _ No If yes, how frequently_________ If yes, what kind (beer, liquor, etc): _________
Have you used recreational drugs? _ Yes _ No If yes, what kind: (marijuana, cocaine, etc).____________________
Have you ever been exposed to: _ Fumes _ Dust _ Solvents _ Lead _ Asbestos _ Other: _______________________
Marital Status: _ Married _ Single _ Divorced _ Widow/Widower If married, health of spouse? ________________
Do you live alone? _ Yes _ No If not, who do you live with? ____
Do you care for anyone else in your home? _ Yes _ No
What is your current activity level? __ Sedentary __ Daily activities __ Occasional exercise __ Light exercise
__ Regular exercise __Extensive exercise
Are you currently on any special diets? _ Regular meals _ Low Cholesterol _ Diabetic _ Gluten free __ Other _____
Work History:

Arc you currently: ___ Working ___ Retired Date: ______________ Disabled Date: _________________
Present Occupation or if retired, Previous Occupation: ____
Previous Occupations: ____
Have you had any foreign travel in the last year? _ Yes _ No

Allergies:
Please list all allergies including medications you are allergic to or have adverse reaction to. Be sure to include foods and other allergies as well:
____

Please list all your medication that you are currently taking. Include all over the counter medications and vitamins. You may attach a list if you need to.

Medication Name	Dose/Strength	Times taken per day?	Who Prescribes	Why do you take this medication?

Patient's Signature ____ Today's Date ______________________

Physician's Signature ____

Physician's Assistant/Nurse Practitioner ___________________________