

MEDICAL ONCOLOGY HEMATOLOGY CONSULTANTS, PA
NEW PATIENT MEDICAL HISTORY FORM

PATIENT NAME _____ **DATE** _____

Please list any drug/medication ALLERGIES : _____

Please name any other physicians you are currently seeing (and list their specialties):

Primary MD- _____ **Others-** _____

MEDICAL HISTORY:

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Pneumonia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N
High cholesterol	<input type="checkbox"/> Y	<input type="checkbox"/> N	Thyroid disease	<input type="checkbox"/> Y	<input type="checkbox"/> N
Heart attack	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y	<input type="checkbox"/> N
Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y	<input type="checkbox"/> N
Angina	<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney disease	<input type="checkbox"/> Y	<input type="checkbox"/> N
Stomach ulcers	<input type="checkbox"/> Y	<input type="checkbox"/> N	High blood pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N
Other cancers	<input type="checkbox"/> Y	<input type="checkbox"/> N			

HAVE YOU EVER HAD SURGERY ON:

Appendix	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hemorrhoids	<input type="checkbox"/> Y	<input type="checkbox"/> N
Tonsils	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hernia	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hysterectomy	<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart	<input type="checkbox"/> Y	<input type="checkbox"/> N
Gallbladder	<input type="checkbox"/> Y	<input type="checkbox"/> N	Teeth	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cataracts	<input type="checkbox"/> Y	<input type="checkbox"/> N	Vascular (veins/arteries)	<input type="checkbox"/> Y	<input type="checkbox"/> N

Any other surgeries (please list) _____

Any hospitalizations (other than surgery or childbirth) _____

Women: # of Pregnancies _____ # of Deliveries _____ Complications Y N

First day of last menses _____ **Age at menopause** _____

FAMILY HISTORY:

Mother's age now _____ **or age when passed away** _____
Her medical problems _____

Father's age now _____ **or age when passed away** _____
His medical problems _____

_____ **brothers/ #** _____ **sisters** _____ **any medical problems/cancers** _____

Do you have relatives with any of the following (please circle):

Cancer (please list types) _____

Heart Attack	Diabetes	Heart Disease	Stroke
Blood Disorders	High Blood Pressure	Asthma	Tuberculosis