Columbus Oncology & Hematology
Serving Ohio Since 1987

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Columbus, Ohio 43214-4359
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6700 Perimeter Drive
Dublin, Ohio 43016-8063
Phone: (614) 442-3130
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Name (Last, First , Middle)	Birth Date	Age	Social Security #	Appointment Date

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone	Email Address

Person Completing This Form: ☐ Patient ☐ Other (Relationship to Patient):

Emergency Contacts	Relation	Home Phone	Cell Phone	Work Phone
Address:			Email**:	
Address:			Email**:	

****Email addresses will only be used for Columbus Oncology and Hematology to contact you if unable to reach by phone and in the case of an emergency. Email is <u>not</u> to be used for you to communicate with us under any circumstance.**

☐ Referring Physician:	Phone:	Fax:	☐ Self Referred

Family Doctor	Specialist - Type:	Specialist - Type:	Specialist - Type:
Name:	Name:	Name:	Name:

If anyone else personally referred you to our practice, who?

Sex	Marital Status	Employment Status	Religion:
☐ M, ☐ F	☐ S, ☐ M, ☐ Life Partner ☐ W, ☐ D, ☐ Separated	☐ Retired, ☐ Working, ☐ Disabled	

Occupation: (current and previous)

History of Chemical Exposure? Agents? When?

Are you ALLERGIC to anything? ☐ Yes ☐ No List all Medications/Allergies and describe your reaction

CURRENT MEDICATIONS (Include prescription, over-the-counter and herbals): **** Please attach additional sheet or add to last page**

Name of Medication	Dose	How often taken	Reason for medication	Length of time taken

CURRENT MEDICAL HISTORY:

What is your medical reason for coming to Columbus Oncology and Hematology Associates?

Please give the history of your current problem: (when it started; symptoms; treatment)

PAST MEDICAL HISTORY: Please check ALL previous illnesses and list additional conditions.

☐ Bleeding problems	☐ High blood pressure	☐ Stroke	☐ Seizure	☐ Heart problems
☐ Circulation problems	☐ Lung problems	☐ Diabetes	☐ Liver problems	☐ Thyroid problems
☐ Kidney/urine problems	☐ Psychological/Psychiatric problems	☐ Frequent infections	☐ HIV/AIDS	☐ Tuberculosis

Please provide information below for the conditions you checked above and other conditions including hospitalizations:

Past Surgeries (include type of surgery and date):

Immunizations: ☐ Pneumonia vaccine ☐ N, ☐ Y Date: | ☐ Influenza (Flu Shot): ☐ N, ☐ Y Date: | ☐ Other

SOCIAL HISTORY

ALCOHOL HISTORY

Do you drink alcoholic beverages regularly (at least 1 drink per month)? ☐ Yes currently ☐ Yes but Quit ☐ Never/rarely

If answered yes to either above question, answer the following questions:

Beverage	Total # of Drinks per Day	Total # of Drinks per Week	Number of Years
☐ Beer , ☐ Wine, ☐ Liquor			

If you have quit drinking, how old were you when you quit? Years old

TOBACCO HISTORY

Have you ever smoked at least 100 cigarettes (5 packs) during your lifetime? ☐ Yes currently ☐ Yes but Quit ☐ No

If Yes, When did you first start smoking cigarettes regularly? Age, If quit , how old were you? Age

On average, how many packs do/did you smoke per day? most packs per day

Any ☐ Childhood and/or ☐ Second hand smoke exposure? If yes, number of years, about number of hours/day

Use of any other tobacco products?

☐ Chewing Tobacco, ☐ Snuff or Dip, ☐ Pipes, ☐ Cigars, How much per day, years used

** Interested in Quitting any tobacco products Please ask for more information and options.

RECREATIONAL DRUGS

Have you ever used any recreational (street) drugs? ☐ Yes currently ☐ Yes but Quit ☐ No

If Yes, What agents and how much?

FAMILY HISTORY:

Are you Adopted? ☐ No, ☐ Yes | Are you a Twin? ☐ No, ☐ Yes | What type of twin? ☐ Identical , ☐ Fraternal

Excluding yourself, how many of each of the following blood-related family members do you have?

Brothers: | Sisters: | Sons: | Daughters:

Remember to include those who are no longer living. Include only **full** brothers or sisters.

Complete the table below for each of your blood relatives who has had cancer or a bleeding or blood related problem . .
If it is a grandparent, aunt or uncle, place in the box a "F" if from your **father's side** or "M" if from your **mother's side of the family**.

Name	Relative Type	F or M	Year Born	Still Living	Age Died	Type of Cancer or Blood Problem	Age Diagnosed

Screening and Sexual History:

Colon screening : ☐ Yes, ☐ No | ☐ Colonoscopy | ☐ Sigmoidoscopy | ☐ Annual hemocult | ☐ Barium enema

Date of test perform: Next Due Any Polyps? ☐ Yes, ☐ No

Bone Density : ☐ Yes, ☐ No Date: Result:

To be answered by <u>WOMEN</u> only:

Mammogram: ☐ Yes, ☐ No, Date _____ Result _____ <u>Pap Smear:</u> ☐ Yes, ☐ No , Date _____ Result _____

Age of first menstrual period? _____ Regular monthly menstrual periods? ☐ Yes, ☐ No, if no when last period _____

Are you now on or have you ever taken birth control pills? ☐ Yes, ☐ No, When? _____ How Long _____

Have you ever used estrogen replacement therapy? ☐ Yes, ☐ No, When? _____ How Long? _____

Have you ever had a miscarriage? ☐ Yes, ☐ No, How many? _____ What Term? _____ When?_____

To be answered by <u>MEN</u> only:

Prostate screening: ☐ PSA : Result if known:_____ Date? _____ ☐ Exam : Date _____

For cancer patients only:

Please complete the **TABLE** below for my **<u>PRIOR</u>** cancer, radiation treatment, or chemotherapy that you may have had:

	Don't know	No	Yes	Year	Kind of cancer or type of disease / condition
Prior Cancers (before current illness):					
Prior Radiation Treatment (not dental x-rays or for broken bones):					
Prior Chemotherapy					

General Health Questions: *Attach additional sheets if needed or add to last page

General	Weight Loss?	☐N,☐Y	Decrease in appetite?	☐N,☐Y	Night sweats?	☐N,☐Y
	Fatigue?	☐N,☐Y	Decrease in energy?	☐N,☐Y	Fever?	☐N,☐Y
If any yes, explain and other general complaints?						
Eyes and Ears	Change in hearing?	☐N,☐Y	Ear pain?	☐N,☐Y	Change in vision?	☐N,☐Y
If any yes, explain and other seeing or hearing complaints?						
Head, Nose, and Throat	Sinus infection/pain?	☐N,☐Y	Nasal Drainage?	☐N,☐Y	Throat pain?	☐N,☐Y
If any yes, explain and other head or necks complaints?						
Cardiovascular			Nighttime Shortness of breath?	☐N,☐Y	Lower leg swelling?	☐N,☐Y
Chest pain?	☐N,☐Y		Decrease in ability to exert oneself?	☐N,☐Y	Able to lie flat?	☐N,☐Y
If any yes, explain and other heart complaints?						
Pulmonary	Shortness of Breath?	☐N,☐Y	Blood in Sputum?	☐N,☐Y	Cough?	☐N,☐Y
If any yes, explain and other lung complaints?						
Gastrointestinal	Difficulty swallowing food?	☐N,☐Y	Indigestion?	☐N,☐Y	Diarrhea?	☐N,☐Y
	Vomiting?	☐N,☐Y	Nausea?	☐N,☐Y	Constipation?	☐N,☐Y
	Abdominal Pain ?	☐N,☐Y	Blood in stool?	☐N,☐Y	Black stool?	☐N,☐Y
If any yes, explain and other abdominal complaints?						
Genitourinary	Blood in urine?	☐N,☐Y	Increase in need to urinate?	☐N,☐Y	Difficulty starting urination?	☐N,☐Y
	Burning or pain with urination?	☐N,☐Y	Increase in urination at night?	☐N,☐Y	Dribbling or unable to control urine?	☐N,☐Y
If any yes, explain and other urination complaints?						
Hematologic	Bleeding after surgery?	☐N,☐Y	Easy bruising/ bleeding?	☐N,☐Y	Lymph node or gland swelling?	☐N,☐Y
	Prior transfusion?	☐N,☐Y	Any history of blood clots?	☐N,☐Y	Nose bleeds, rectal bleeding or bleeding at other site? (specify)	☐N,☐Y
If any yes, explain and other hematologic complaints?						
Neurologic	Headaches, troublesome or frequent?	☐N,☐Y	Decrease in ability to walk?	☐N,☐Y	Seizures?	☐N,☐Y
	Numbness in hands and feet?	☐N,☐Y	Decrease in muscle strength	☐N,☐Y	Tingling in hands/ feet?	☐N,☐Y
If any yes, explain and other neurologic complaints?						
Psychiatric	Change in mood?	☐N,☐Y	Depression?	☐N,☐Y	Change in behavior with family/friends?	☐N,☐Y
	Anxious?	☐N,☐Y	Memory loss?	☐N,☐Y	Change in ability to think?	☐N,☐Y
If any yes, explain and other psychiatric complaints?						
Endocrine	Diabetes?	☐N,☐Y	Hypothyroidism?	☐N,☐Y	Hyperthyroidism?	☐N,☐Y
If any yes, explain and other endocrinology complaints?						
Skin	Rashes?	☐N,☐Y	Infections?	☐N,☐Y	Ulcers or open sores?	☐N,☐Y
	Yellow skin?	☐N,☐Y	If any yes, explain and other skin complaints?			

Any additional comments, information, issues you would like to discuss or provide to us:

Physician Notes: **- Office use Only -**

☐ **By checking this box, I confirm that I have reviewed this form in its entirety.**

Physician Signature : _____

Columbus Oncology and Hematology Associates