

Columbus Oncology and Hematology Associates An Ohio Oncology & Hematology, LLC Practice

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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:	<input type="checkbox"/> Patient	<input type="checkbox"/> Other (Relationship to Patient):			
Emergency Contacts		Relation	Home Phone	Cell Phone	Work Phone
1			() -	() -	() -
Address:				Email**:	
2			() -	() -	() -
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.					
<input type="checkbox"/> Referring Physician:			Phone: () -	Fax: () -	<input type="checkbox"/> Self Referred
Family Doctor		Specialist - Type:		Specialist - Type:	
Name:		Name:		Name:	
If anyone else personally referred you to our practice, who?					
Sex <input type="checkbox"/> M, <input type="checkbox"/> F		Marital Status <input type="checkbox"/> S, <input type="checkbox"/> M, <input type="checkbox"/> Life Partner <input type="checkbox"/> W, <input type="checkbox"/> D, <input type="checkbox"/> Separated		Employment Status <input type="checkbox"/> Retired, <input type="checkbox"/> Working, <input type="checkbox"/> Disabled	
Religion:					
Occupation: (current and previous)					
History of Chemical Exposure? Agents? When?					
Are you ALLERGIC to anything? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Seizure	<input type="checkbox"/> Heart problems
<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver problems	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Kidney/urine problems	<input type="checkbox"/> Psychological/Psychiatric problems	<input type="checkbox"/> Frequent infections	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> 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
<input type="checkbox"/> Beer, <input type="checkbox"/> Wine, <input type="checkbox"/> 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 WOMEN only:

Mammogram: Yes, No, Date _____ Result _____ Pap Smear: 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 MEN only:

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

For cancer patients only:

Please complete the **TABLE** below for my **PRIOR** 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?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Decrease in appetite?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Night sweats?	<input type="checkbox"/> N, <input type="checkbox"/> Y
	Fatigue?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Decrease in energy?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Fever?	<input type="checkbox"/> N, <input type="checkbox"/> Y

If any yes, explain and other general complaints?

Eyes and Ears	Change in hearing?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Ear pain?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Change in vision?	<input type="checkbox"/> N, <input type="checkbox"/> Y
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If any yes, explain and other seeing or hearing complaints?

Head, Nose, and Throat	Sinus infection/pain?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Nasal Drainage?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Throat pain?	<input type="checkbox"/> N, <input type="checkbox"/> Y
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If any yes, explain and other head or necks complaints?

Cardiovascular	Nighttime Shortness of breath?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Lower leg swelling?	<input type="checkbox"/> N, <input type="checkbox"/> Y
	Chest pain?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Decrease in ability to exert oneself?	<input type="checkbox"/> N, <input type="checkbox"/> Y
	Able to lie flat?	<input type="checkbox"/> N, <input type="checkbox"/> Y		

If any yes, explain and other heart complaints?

Pulmonary	Shortness of Breath?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Blood in Sputum?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Cough?	<input type="checkbox"/> N, <input type="checkbox"/> Y
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If any yes, explain and other lung complaints?

Gastrointestinal	Difficulty swallowing food?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Indigestion?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Diarrhea?	<input type="checkbox"/> N, <input type="checkbox"/> Y
	Vomiting?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Nausea?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Constipation?	<input type="checkbox"/> N, <input type="checkbox"/> Y
	Abdominal Pain ?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Blood in stool?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Black stool?	<input type="checkbox"/> N, <input type="checkbox"/> Y

If any yes, explain and other abdominal complaints?

Genitourinary	Blood in urine?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Increase in need to urinate?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Difficulty starting urination?	<input type="checkbox"/> N, <input type="checkbox"/> Y
	Burning or pain with urination?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Increase in urination at night?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Dribbling or unable to control urine?	<input type="checkbox"/> N, <input type="checkbox"/> Y

If any yes, explain and other urination complaints?

Hematologic	Bleeding after surgery?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Easy bruising/ bleeding?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Lymph node or gland swelling?	<input type="checkbox"/> N, <input type="checkbox"/> Y
	Prior transfusion?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Any history of blood clots?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Nose bleeds, rectal bleeding or bleeding at other site? (specify)	<input type="checkbox"/> N, <input type="checkbox"/> Y

If any yes, explain and other hematologic complaints?

Neurologic	Headaches, troublesome or frequent?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Decrease in ability to walk?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Seizures?	<input type="checkbox"/> N, <input type="checkbox"/> Y
	Numbness in hands and feet?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Decrease in muscle strength	<input type="checkbox"/> N, <input type="checkbox"/> Y	Tingling in hands/ feet?	<input type="checkbox"/> N, <input type="checkbox"/> Y

If any yes, explain and other neurologic complaints?

Psychiatric	Change in mood?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Depression?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Change in behavior with family/friends?	<input type="checkbox"/> N, <input type="checkbox"/> Y
	Anxious?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Memory loss?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Change in ability to think?	<input type="checkbox"/> N, <input type="checkbox"/> Y

If any yes, explain and other psychiatric complaints?

Endocrine	Diabetes?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Hypothyroidism?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Hyperthyroidism?	<input type="checkbox"/> N, <input type="checkbox"/> Y
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If any yes, explain and other endocrinology complaints?

Skin	Rashes?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Infections?	<input type="checkbox"/> N, <input type="checkbox"/> Y	Ulcers or open sores?	<input type="checkbox"/> N, <input type="checkbox"/> Y
	Yellow skin?	<input type="checkbox"/> N, <input type="checkbox"/> 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 : _____

**Drs. Sonia Abuzakhm, Brent Behrens, Scott Blair, Christopher George, Andrew Grainger,
Joseph Hofmeister, Peter Kourlas, Kavya Krishna, Phillip Kuebler, Nse Ntukidem, Thomas Sweeney**

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