

## Columbus Oncology and Hematology Associates

810 Jasonway Ave. Columbus, OH 43214, [www.coainc.net](http://www.coainc.net) Ph: 614.442.3130, Fax: 614.442.3145

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:		Specialist - Type:
Name:	Name:		Name:		Name:
If anyone else personally referred you to our practice, who?					
Sex	Marital Status		Employment Status		Religion:
<input type="checkbox"/> M, <input type="checkbox"/> F	<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		<input type="checkbox"/> Retired, <input type="checkbox"/> Working, <input type="checkbox"/> Disabled		
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					
<b>CURRENT MEDICATIONS (Include prescription, over-the-counter and herbals): ** Please attach additional sheet or add to last page</b>					
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)

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**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:

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**Past Surgeries** (include type of surgery and date):

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<b>Immunizations:</b> <input type="checkbox"/> Pneumonia vaccine <input type="checkbox"/> N, <input type="checkbox"/> Y Date:	<input type="checkbox"/> Influenza (Flu Shot): <input type="checkbox"/> N, <input type="checkbox"/> Y Date:	<input type="checkbox"/> Other
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**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**

<b>General</b>	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?  
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<b>Eyes and Ears</b>	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?  
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<b>Head, Nose, and Throat</b>	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?  
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<b>Cardiovascular</b>	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?

If any yes, explain and other heart complaints?  
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<b>Pulmonary</b>	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?  
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<b>Gastrointestinal</b>	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?  
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<b>Genitourinary</b>	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?  
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<b>Hematologic</b>	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?  
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<b>Neurologic</b>	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?  
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<b>Psychiatric</b>	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?  
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<b>Endocrine</b>	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?  
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<b>Skin</b>	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:**

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

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

Physician Signature : \_\_\_\_\_

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