Columbus Oncology & Hematology
Serving Ohio Since 1987

810 Jasonway Ave
Columbus, OH 43214
www.coainc.net
Phone: 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: ☐ 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 not 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 : _____

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