Columbus Oncology & Hematology
Serving Ohio Since 1987

Jasonway Cancer Center
810 Jasonway Ave.
Columbus, Ohio 43214-4359

Phone: (614) 442-3130
Fax: (614) 442-3150

Dublin Cancer Center
6700 Perimeter Drive
Dublin, Ohio 43016-8063

Westerville Cancer Center
300 Polaris Pkwy, Suite 330
Westerville, Ohio 43082-7813

Appointment Date: _____

Location: _____

Provider: _____

Name (Last, First, Middle)	Birth Date	Age	Social Security #

Address	City	State	Zip Code

Cell Phone	Home Phone	Work Phone	Email Address

Preferred contact method: ☐ Cell phone ☐ Work phone ☐ Home phone ☐ Email

***Email addresses will only be used to setup patient portal and contact you if you cannot be reach by phone.**

Sex at birth	Gender Identity	Marital Status	Employment Status	Occupation (Current or previous)	Religion
☐ Male ☐ Female		☐ Single ☐ Life Partner ☐ Divorced ☐ Married ☐ Widowed ☐ Separated	☐ Working ☐ Retired ☐ Disabled		

EMERGENCY CONTACTS List at least 2:

Name:	Relation:	Cell phone:	Address:
Name:	Relation:	Cell phone:	Address:

PROVIDER INFORMATION

☐ Referred ☐ Self-Referred	Referring Physician's First & Last Name:	Phone:	Primary Care Doctor's First & Last Name:

Dentist's First & Last Name:	Other (Name and type):	Other (Name and type):

PHARMACY

Name, Address & Phone Number of preferred pharmacy:	Mail order pharmacy:

IMMUNIZATIONS

☐ Pneumonia vaccine Date:	☐ Influenza (Flu Shot) Date:	☐ Shingles Date:	☐ Last COVID Date:	☐ RSV Date:	☐ Other Date:

ALLERGIES List all allergies, describe your reaction:

REASON FOR REFERRAL Provide the history of your current problem (when it started; symptoms; treatment):

Patient Name: _____ DOB _____

CURRENT MEDICATIONS Include prescription, over-the-counter & herbals. * Please attach an additional sheet or add to last page:

Name of Medication	Dose	How often taken	Reason for Medication	# of Years on Medication

MEDICAL HISTORY List all medical problems and past surgeries: *(ie. diabetes, hypertension, coronary artery disease, etc)*

CANCER HISTORY If you have a history of cancer, list the type of cancer and the treatment you've received:

Have you had genetic testing? ☐ Yes ☐ No Any genetic changes?

FAMILY HISTORY List only cancer, blood, or genetic problems:

Relative Type	Father or Mother's side	Type of Cancer, Blood, or Genetic Problem	Age at Diagnosis

SOCIAL HISTORY

Tobacco

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

If you've quit, year did you quit: | Number of packs you smoke(d) per day on average: | Number of years you have smoked:

Tobacco products used: ☐ Marijuana ☐ Vape ☐ Chewing tobacco/Dip ☐ Pipe ☐ Cigar

Alcohol

Do you drink alcoholic beverages regularly (at least 1 drink per month)? ☐ No ☐ Yes

If **Yes** to the above, provide the following:	Total # of Drinks per Week:	Maximum Drinks per Day:	Type of Drink(s):

Recreational Drugs

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

If **Yes** to the above, which agents have you used, and how much:

SCREENING HISTORY

Patient Name: _____ DOB _____

Type of Screening	Received	Date of Test	Results of Test	Due Next
Colonoscopy	☐ Yes ☐ No			
Cologuard	☐ Yes ☐ No			
Upper endoscopy (EGD)	☐ Yes ☐ No			
Bone Density	☐ Yes ☐ No			
Mammogram	☐ Yes ☐ No			
PSA	☐ Yes ☐ No			

To be answered by WOMEN only

Are you: ☐ Pre-menopausal ☐ Perimenopausal OR ☐ Post-menopausal

Are you currently pregnant? ☐ Yes ☐ No Are you planning to become pregnant? ☐ Yes ☐ No

When was your last mentrual period? .....

Oral Contraceptives (OCPs)? ☐ Yes ☐ No If Yes, for how long? .....

Hormone Replacement Therapy (HRT)? ☐ Yes ☐ No If Yes, for how long? .....

GENERAL HEALTH QUESTIONS: Select all of the following you are you experiencing

**Attach additional sheets if needed*

General

- ☐ Weight Loss
- ☐ Decrease in appetite
- ☐ Fatigue
- ☐ Night sweats
- ☐ Fever
- ☐ Pain: Chronic or new

If yes, please explain:

Gastrointestinal

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Blood in stool

If yes, please explain:

Neurologic

- ☐ Persistent headaches
- ☐ History of Stroke
- ☐ Seizures
- ☐ Numbness or tingling in hands or feet

If yes, please explain:

Other

- ☐ Change in hearing
- ☐ Change in vision
- ☐ Diabetes
- ☐ Rash
- ☐ Kidney Disease

If yes, please explain:

Heart/Lung

- ☐ Shortness of breath
- ☐ Cough
- ☐ Chest pain
- ☐ Lower leg swelling

If yes, please explain:

Blood

- ☐ Bleeding after surgery
- ☐ Easy bruising/ bleeding
- ☐ Lymph node or gland swelling
- ☐ History of blood transfusions

If yes, please explain:

Mental Health

- ☐ Difficulty sleeping
- ☐ Anxiety
- ☐ Depression symptoms
- ☐ Memory loss

If yes, please explain:

ADDITIONAL INFORMATION

Use this space to note any additional comments, information, issues you would like us to know: