Columbus	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			Appointment Date:			
Oncology & Hematology Serving Obio Since 1987			Westerville Cancer Center 300 Polaris Pkwy, Suite 330 Westerville, Ohio 43082-7813		te 330	Location: Provider:			
Name (Last, First, Middle)		Birth Date			Age	So	cial Security #		
Address		1		City		St	ate 2	Zip Code	
Cell Phone	Home Phone	Work F	Phone		Email Addre	ess			
	Cell phone 🔲 Work pho	-	mail address u cannot be			to setup j	oatient portal a	nd conto	act you
Sex at birth Gender Iden Gender Iden Hale Female	Single I	ital Status ife Partner Vidowed	Divor	ced	0		Occupati (Current or pre		Religion

EMERGENCY CONTACTS List at least 2:

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

PROVIDER INFORMATION

	Referred	Referring Physician's First & Last Name:		Phone:	Primary Care D	octor's First & Last Name:
	Self-Referred					
Dentist's First & Last Name: Other (Na		Other (Name a	and type):		Other (Name and type):	

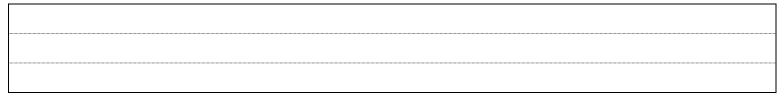
PHARMACY

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

IMMUNIZATIONS

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

ALLERGIES List all allergies, describe your reaction:



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

CURRENT MEDICATIONS	Include prescript	ion, over-the-counter & herb	als. * Please attach an additio	onal sheet or add to last page:

Dose	How often taken	Reason for Medication	# of Years on Medication
	Dose	Dose How often taken	Dose How often taken Reason for 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 le lifetime? If you've quit, year did you quit:	east 100 cigarettes (5 packs) during your INNO Yes, currently Yes, but 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					
	Do you drink alcoholic beverages regularly (at least 1 drink per month)?						
Alcohol	If Yes to the above, provide the following:	Total # of Drinks per Week: Maximum Drinks per Day: Type of Drink(s):					
Recreational	Have you ever used any red	creational (street) drugs? 🗌 No 📄 Yes, currently 📄 Yes, but quit					
Drugs	If Yes to the above, which agents	have you used, and how much:					

SCREENING HISTORY

Patient Name:

Yes Yes Yes Yes Yes Yes Yes	No No No No No No No						
Yes Yes	No						
Yes							
	□ No						
Ves	_						
103	D No						
Yes	No No						
urrently p ?	regnant?	Yes Yes No No e followi e followi Blo fter surger ng/ bleedin e or gland blood trans	No Are you p If Yes, If Yes, If Yes, If Yes, ng you are you exp Neuro Persistent heada History of Strol Seizures Numbness or the or feet If yes, please explained od y ng swelling	plann , for h , for h oerien logic aches ke ngling	ing to becor ow long? ow long? cing cing g in hands g in hands Difficul Anxiety Depress Memor	*Attach a *Attach a Cha Cha Cha Diat Rasi Kidu If yes, pl Men ty sleeping ion sympt y loss	additional sheets if neede Other nge in hearing nge in vision betes n ney Disease ease explain: tal Health g
	Yes Prince Princ	Yes No Yes No Pre-menopausal rrently pregnant? Yes IONS: Select all of th Gastrointestinal Abdominal pain Constipation Diarrhea Nausea Blood in stool yes, please explain: Bleeding af Easy bruisin Lymph nod History of b	Yes No Pre-menopausal Per rrently pregnant? Yes Yes No IONS: Select all of the followi Gastrointestinal Abdominal pain Constipation Diarrhea Nausea Blood in stool yes, please explain: Bleeding after surger Easy bruising/ bleedin Lymph node or gland	Yes No Yes No Pre-menopausal Perimenopausal OR rrently pregnant? Yes No Are you Yes No If Yes OR Yes No Abdominal pain Persistent head Constipation History of Stro Diarrhea Seizures Nausea Numbness or ti or feet Blood in stool If yes, please explain: If yes, please explain: If yes, please explaing Bleeding after surgery Easy bruising/ bleeding Lymph node or gland swelling History of blood transfusions	Yes No Yes No Pre-menopausal Perimenopausal OR rrently pregnant? Yes No Are you plann Yes No If Yes, for h IONS: Select all of the following you are you experien Gastrointestinal Neurologic Abdominal pain Persistent headaches Constipation History of Stroke Diarrhea Seizures Nausea Numbness or tingling or feet yes, please explain: If yes, please explain: Wes, please explain: If yes, please explain: Blood Bleeding after surgery Easy bruising/ bleeding Lymph node or gland swelling History of blood transfusions History of blood transfusions	Yes No Pre-menopausal Perimenopausal OR Post-menor Pre-menopausal Yes No Are you planning to becor Yes No If Yes, for how long?	Yes No Pre-menopausal Perimenopausal OR Post-menopausal rrently pregnant? Yes No Are you planning to become pregna Yes No If Yes, for how long?

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