

Place Label Here

PATIENT MEDICAL HISTORY FORM

Dear Patient,

Please return completed packet with signature pages to the front desk.

Patient Name: _____

DOB: ____/____/____ **Age:** _____ Male Female **SS#:** _____

Primary Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: Preferred (_____) _____

Cell Phone: Preferred (_____) _____

Secondary Address: _____

City: _____ **State:** _____ **Zip:** _____

May we leave a message on your answering machine / voicemail? Yes No

Email Address: _____ **May we email you?** Yes No

Preferred Language: _____

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Race: Native American or Alaska Native Asian Black or African American

Native Hawaiian or Other Pacific Islander White Other

Pharmacy Name: _____

Pharmacy Phone # and Cross Streets: _____

(Internal Use Only)

MRN#: _____

Patient Name: _____ **DOB:** _____

Primary Care Physician: _____ Phone: _____

Referring Physician (if different): _____ Phone: _____

Please list any additional Physicians you see: (Include Phone #):

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

Emergency Contact Name:

Relationship: _____ Phone: (_____) _____

Employment Status:

Employed/Self Employed Unemployed Retired Disabled

Occupation (or Former Occupation): _____

Name of Employer: _____ Work Phone: (_____) _____

Advanced Directives:

Living Will Yes No Unknown

Durable Power of Attorney Yes No Unknown

DNR Yes No Unknown

Patient Name: _____ DOB: _____

Medical History Have you EVER had any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neurological Disorder/Chronic Headaches | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Psychiatric Disorder/Illness | <input type="checkbox"/> Blood Pressure Disorder/Hypertension | <input type="checkbox"/> Pulmonary Embolism/DVT/Blood Clots |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cholesterol Disorder/Hyperlipidemia |
| <input type="checkbox"/> Seizures or Epilepsy | <input type="checkbox"/> COPD | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Eye Disorder (i.e. Glaucoma) |
| <input type="checkbox"/> Urinary/Kidney Disorder | <input type="checkbox"/> Heart Attack/Heart Disease/Atrial Fib | <input type="checkbox"/> Other |

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Surgery History Please list ANY surgeries you have had and the approximate date.

Procedure	Date	Complications

Prior Cancer Treatment Do you currently have cancer? Yes No

Type of Cancer	Year Diagnosed	Treatment	Hospital/Doctor's Office Where You Received Treatment
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:

Allergies

Are you allergic to any medications or other substances? Yes No Please list allergies and reactions:

Patient Name: _____ DOB: _____

Medication List

Medication Name	Dose	Frequency

Do you have additional medications not listed above? Yes No If yes, please use the back of this page to list all others.

Health Maintenance

Date of last bone density: _____

Date of last pap smear: _____ Have you ever had an abnormal PAP smear? Yes No

Date of last mammogram: _____ Was that mammogram normal? Yes No

Date of last colonoscopy: _____ Was that colonoscopy normal? Yes No

Family Medical History Please indicate any major conditions, including cancers, that your immediate family members have had.

Relative	Condition and Description	Living?	If deceased, at what age?
Mother		Y N	
Father		Y N	
Sibling		Y N	
Sibling		Y N	
Sibling		Y N	
Grandparent		Y N	
Grandparent		Y N	
Other		Y N	

Social History

Do you currently smoke? Yes No If no, previously? Yes No

Years smoked _____ Packs per day _____

Do you use other tobacco products? Yes No Consume Alcohol? Yes No If yes, drinks per week: _____

Do you do any drugs (including marijuana)? Yes No If yes, what drug and for how long? _____

Marital Status: Single Married Partnered Separated Divorced Widowed

Do you suffer from domestic violence? Yes No Do you feel safe at home? Yes No

Patient Name: _____ DOB: _____

Review of Systems Please indicate ALL that you have experienced within the last 6-12 months.

General

- | | | | |
|---------------------------------|--|---|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Feeling Tired | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Feeling Poorly | |

Eyes

- | | | | |
|---|--|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Itchy Eyes |
| <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Eyesight Problems | | |

Ear/Nose/Throat

- | | | | |
|---|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Earache | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Hoarseness | |

Heart

- | | | | |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Slow Heart Rate |
| <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Fast heart rate | <input type="checkbox"/> Leg pain, discomfort or fatigue during walking | |

Lungs/Breathing

- | | | | |
|--|--------------------------------|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Trouble breathing with exertion | | <input type="checkbox"/> Trouble breathing when lying flat | |

Gastrointestinal

- | | | | |
|------------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood in stool |

Skin

- | | | | |
|---------------------------------------|-------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Acne | <input type="checkbox"/> Itching | <input type="checkbox"/> Change in mole |
| <input type="checkbox"/> Skin Lesions | <input type="checkbox"/> Skin Wound | <input type="checkbox"/> Breast Lump | |

Neurological

- | | | | |
|--------------------------------------|--|------------------------------------|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Limb Weakness | <input type="checkbox"/> Confused | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty Walking |

Psychiatric

- | | | | |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Suicidal | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Disturbed Sleep |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Change in Personality | |

Endocrine

- | | | | |
|---------------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Feeling Weak | <input type="checkbox"/> Deepening Voice | | |

Hem/Lymph

- | | | | |
|-------------------------------|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Swollen Glands |
|-------------------------------|--|--|---|

Patient Name: _____ DOB: _____

CONSENT TO DISCLOSE MEDICAL INFORMATION

Please check one of the following:

_____ I give permission to the employees of Cancer & Blood Specialists of Arizona (CBSA/AOP), a division of American Oncology Partners, P.A. to disclose my Protected Health Information to me and the following individual(s):

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

_____ I request that all my Protected Health Information be disclosed ONLY to me and no other **individual(s)**.

I understand that I may revoke or change this Consent at any time by filling out another Consent form to replace this one.

Patient Name (Print)

Date

Patient or Guarantor (Signature)