Hematology & Oncology
Consultants of Pennsylvania, P. C.

Patient Health History

Name: _____ Date of birth: _____ Age: _____

Today's Date: _____ Occupation: _____

Primary Care Physician: _____ Phone number: _____

Referring Physician: _____ Phone number: _____

Current problem or reason for visit: _____

Name of Pharmacy: _____ Pharmacy phone: _____

PAST MEDICAL HISTORY:

Problem	Date of onset	Additional Medical History
Heart Disease	_____	_____
High Blood Pressure	_____	_____
Diabetes	_____	_____
Stroke	_____	_____
Lung Disease	_____	_____
Liver Disease/	_____	_____
Kidney Disease	_____	_____
Anemia	_____	_____
Cancer (Tumors)	_____	_____
Thyroid Problems	_____	_____
Arthritis	_____	_____
Epilepsy or Seizures	_____	_____
Bowel Problems/Polyps	_____	_____
Bleeding Disorders	_____	_____
Clotting Problems	_____	_____
Psychiatric Problems	_____	_____

SURGICAL HISTORY:

Year	Operation	Surgeon	Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES/DRUG REACTIONS: _____

_____

MEDICATIONS:

_____ _____

_____ _____

_____ _____

_____ _____

HAVE YOU EVER USED:	NO	YES	IF YES, WHAT AMOUNT
Tobacco	____	_____	_____
Alcohol	____	_____	_____
Illicit Drugs	____	_____	_____

Are You: Single ____ Married _____ Widowed _____ Divorced_____

Number of Children; _____

FAMILY HISTORY:	If Living Age	Medical Status	If Deceased Age	Cause of Death
Natural Father	_____	_____	_____	_____
Natural Mother	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Daughters	_____	_____	_____	_____
	_____	_____	_____	_____
Sons	_____	_____	_____	_____

OTHER IMPORTANT FAMILY HISTORY: _____

_____

_____

_____

IF YOU HAVE ANY OF THE FOLLOWING: MARK YES OR NO ON THE LINE NEXT TO ITEM

GENERAL:
Fevers or night sweats _____
Weight loss _____
Weight Gain _____
Loss of appetite _____

SKIN:
Skin Rashes _____
Itching _____
Easy bruising _____
Change in wart or mole _____

EYES, EARS, NOSE and THROAT:
Blurred vision _____
Double vision _____
Do you wear glasses? _____
Hearing loss? _____
Ringing in the ears _____
Do you wear a hearing aid? _____
Nosebleeds _____
Sore throat _____
Hoarseness _____

HEART and LUNG:
Lightheadedness or dizziness _____
Palpitations _____
Chest pain or discomfort _____
Shortness of breath with _____
Activity _____
Cough _____
Coughing up blood _____
Wheezing _____

PSYCHOLOGICAL:
Anxiety _____
Depression _____

GASTROINTESTINAL:
Nausea and/or vomiting _____
Difficulty or pain with swallowing _____
Vomiting up blood _____
Abdominal pain _____
Constipation _____
Diarrhea _____
Black Stools _____
Bloody Stools _____

URINARY TRACT:
Pain with urination _____
Blood in urine _____
Do you wake at night to urinate? _____
Incontinent of urine _____

MUSCULOSKELETAL:
Joint aches _____
Muscle aches _____
Bone pain _____

NEUROLOGIC:
Headache _____
Fainting spells _____
Tremor or hands shaking _____
Weakness _____
Difficulty falling asleep _____
Do you wake-up frequently during the night? _____
Difficulty with memory _____

HAVE YOU EVER:
Received a blood transfusion? _____
Had a positive skin test for Tuberculosis (TB) _____
How many times have you been pregnant? _____
Date of last colonoscopy or Sigmoidoscopy _____
Date of last prostate check _____