



SUBURBAN HEMATOLOGY-ONCOLOGY ASSOCIATES, PC

NAME _____

DATE _____

PATIENT PROFILE

Place of birth _____

Occupation _____

Tobacco use _____

Highest Grade Completed _____

Religion _____

Alcohol use _____

PAST MEDICAL HISTORY – (Check If Appropriate)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other heart disease | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Intestinal disease | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney/bladder disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> High cholesterol |

LIST ALL MEDICATIONS

Drug	Dose	Frequency
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

LIST ALL OPERATIONS

Procedure	Date	Hospital
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

LIST ALL ALLERGIES

1. _____
2. _____
3. _____

FAMILY HISTORY

	<u>If Living</u>		<u>If Deceased</u>	
	Age	Health	Age at death	Cause
Father	_____			
Mother	_____			
Brother/Sister	_____			

Husband/Wife	_____			
Children	_____			

Have any blood relatives ever had? (Check If Appropriate)

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney disease | _____ |

Have you had any of these in the last three months?

<u>NO</u>	<u>YES</u>	<u>NO</u>	<u>YES</u>
GENERAL		INTESTINAL	
<input type="checkbox"/> Change in weight	<input type="checkbox"/>	<input type="checkbox"/> Nausea / Vomiting	<input type="checkbox"/>
<input type="checkbox"/> Fever / chills	<input type="checkbox"/>	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/>
<input type="checkbox"/> Night sweats	<input type="checkbox"/>	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/>
SKIN		<input type="checkbox"/> Abdominal pain / swelling	<input type="checkbox"/>
<input type="checkbox"/> Itching	<input type="checkbox"/>	<input type="checkbox"/> Yellow jaundice	<input type="checkbox"/>
<input type="checkbox"/> Rash	<input type="checkbox"/>	<input type="checkbox"/> Blood in stool / black stool	<input type="checkbox"/>
<input type="checkbox"/> Change in mole	<input type="checkbox"/>	<input type="checkbox"/> Diarrhea / constipation	<input type="checkbox"/>
GLANDS		<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/>
<input type="checkbox"/> Heat / cold intolerance	<input type="checkbox"/>	URINARY	
<input type="checkbox"/> X-ray treatments to neck	<input type="checkbox"/>	<input type="checkbox"/> Burning / painful urination	<input type="checkbox"/>
<input type="checkbox"/> Excessive thirst / urination	<input type="checkbox"/>	<input type="checkbox"/> Blood in urine	<input type="checkbox"/>
EENT		<input type="checkbox"/> Nighttime urination	<input type="checkbox"/>
<input type="checkbox"/> Change in vision	<input type="checkbox"/>	<input type="checkbox"/> Change in urine stream	<input type="checkbox"/>
<input type="checkbox"/> Double Vision	<input type="checkbox"/>	<input type="checkbox"/> Sores on genitals	<input type="checkbox"/>
<input type="checkbox"/> Difficulty hearing	<input type="checkbox"/>	SKELETAL	
<input type="checkbox"/> Frequent bloody nose	<input type="checkbox"/>	<input type="checkbox"/> Joint pain / stiffness	<input type="checkbox"/>
<input type="checkbox"/> Sinus infection	<input type="checkbox"/>	<input type="checkbox"/> Back pain	<input type="checkbox"/>
<input type="checkbox"/> Hoarseness	<input type="checkbox"/>	NEUROLOGICAL	
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/> Frequent / severe headache	<input type="checkbox"/>
<input type="checkbox"/> Sores in mouth	<input type="checkbox"/>	<input type="checkbox"/> Numbness / tingling	<input type="checkbox"/>
HEART / LUNGS		<input type="checkbox"/> Incoordination	<input type="checkbox"/>
<input type="checkbox"/> Chest pain	<input type="checkbox"/>	<input type="checkbox"/> Limb weakness	<input type="checkbox"/>
<input type="checkbox"/> Cough	<input type="checkbox"/>	<input type="checkbox"/> Psychiatric illness	<input type="checkbox"/>
<input type="checkbox"/> Coughing blood	<input type="checkbox"/>	<input type="checkbox"/> Unusual anxiety/depression	<input type="checkbox"/>
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol addiction	<input type="checkbox"/>
<input type="checkbox"/> Wheezing	<input type="checkbox"/>	FOR WOMEN	
<input type="checkbox"/> Irregular / racing heartbeat	<input type="checkbox"/>	<input type="checkbox"/> Bleeding between periods	<input type="checkbox"/>
<input type="checkbox"/> Black out spells	<input type="checkbox"/>	<input type="checkbox"/> Bleeding since menopause	<input type="checkbox"/>
<input type="checkbox"/> Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/> Pain in female organs	<input type="checkbox"/>
<input type="checkbox"/> Aching in legs when walking	<input type="checkbox"/>	<input type="checkbox"/> Breast lump/ pain	<input type="checkbox"/>
BLOOD		<input type="checkbox"/> Nipple discharge	<input type="checkbox"/>
<input type="checkbox"/> Anemia	<input type="checkbox"/>	FOR MEN	
<input type="checkbox"/> Unusual dietary craving	<input type="checkbox"/>	<input type="checkbox"/> Lump / pain in testicle	<input type="checkbox"/>
<input type="checkbox"/> Excessive bruising / bleeding	<input type="checkbox"/>	<input type="checkbox"/> Impotence	<input type="checkbox"/>
<input type="checkbox"/> Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/> Discharge	<input type="checkbox"/>

