NEW PATIENT HISTORY FORM – Hematology & Oncology Consultants, PC

Name: ______________________________________ **Date of Birth:** ________________________

Consulting / Referring Physician (Who sent you to our practice?) ______________________________

Allergies: ____

CURRENT MEDICATIONS: List all prescription, over-the-counter, or "natural"/ herbal medications.
Please list name, dose, and how often taken.

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

Medical Illnesses: Do you have any of the following:

___ High blood pressure
___ Diabetes
___ Heart attack / Heart failure
___ Atrial fib (irregular heart)
___ Emphysema / Bronchitis
___ Arthritis or Gout
___ Thyroid disease
___ Stroke
___ Liver disease
___ High cholesterol
___ Depression
___ Kidney disease

Previous surgeries/hospitalizations: (please include year and Doctor, if known)

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

FAMILY HISTORY:

	Alive	Deceased	Medical Problems	Age now or age when deceased
Mother				
Father				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Other				
Other				

Health Habits and Social History:

Tobacco use: ☐ Never ☐ Previously/Quit? When? __________ ☐ Currently smoke (packs per day ___________)

Alcohol use: ☐ Never ☐ Previously/Quit? When? __________ ☐ Currently drink (how much________________)

Marital status: ☐ married ☐ single ☐ widowed ☐ divorced Number of children: ____________

Who lives with you? _________________________ Current or Previous work _______________________