MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

Todays Date_____ **Name** _____ **Date of Birth** _____**AGE** _____

Allergies _____ **No Allergies** ☐

Occupation_____ **Retired** ☐ **Daily Exercise: YES** ☐ **NO** ☐

Married ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐ **Number of Children** _____ **Number of Pregnancies**_____

Smoking: YES ☐ **NO** ☐ _____ **Packs Per Day for** _____ **Years** **Quit Smoking** _____ **Years / Months Ago**

Alcohol: YES ☐ **NO** ☐ _____ **Drinks Per Day. Drug Use: YES** ☐ **NO** ☐ **If Yes**_____

Date of Last Mammogram _____ **Date of Last Colonoscopy** _____

Please List All Surgeries With Dates (year)	Please List All Illnesses/Serious Injuries With Dates (year)

Family History (check only those boxes that apply): ☐ **Diabetes** ☐ **Heart Disease** ☐ **High Blood Pressure**

☐ **Stroke** ☐ **TB** ☐ **Cancer** ☐ **Kidney Disease** ☐ **Anemia** ☐ **Arthritis** ☐ **Mental Illness**

Mother: ☐ **Living** ☐ **Deceased Age Deceased** _____ **Cause of Death** _____

Father: ☐ **Living** ☐ **Deceased Age Deceased** _____ **Cause of Death** _____

Do you have a Living Will? ☐ **Yes** ☐ **No**

How is your present appetite? GOOD ☐ **FAIR** ☐ **POOR** ☐

Have you experienced any recent weight loss? YES ☐ **NO** ☐ **If yes, how much weight loss?** _____

Do you live alone? YES ☐ **NO** ☐ **If yes, is there someone who helps you prepare the meals? YES** ☐ **NO** ☐

Do you have any oral or dental problems that might interfere with chewing, eating or swallowing? YES ☐ **NO** ☐
If yes, please explain: _____
_____

When did you first notice symptoms related to your present illness?

_____

_____

What were the symptoms?

_____

_____

When did you first see a doctor for your present illness? _____

Have you been hospitalized for this illness? YES ☐ **NO** ☐

Name of hospital: _____ **Date:** _____

Was a biopsy performed? YES ☐ **NO** ☐ **Did you have surgery? YES** ☐ **NO** ☐

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Have you received chemotherapy? YES ☐ NO ☐ **If yes, where?** _____

Have you had any previous radiation therapy? YES ☐ NO ☐

If yes, where? _____ **When?**_____

Have you had recent X-rays, CT scans, PET scans or MRI's ? YES ☐ NO ☐

If yes, where? _____ **When?**_____

PATIENT NAME: _____

Please Complete By Checking Yes or No to All That Apply

CONSTITUTIONAL	Y	N	*RESPIRATORY*	Y	N	*HEMATOLOGIC/LYMPH*	Y	N
Weight Loss			Cough			Easy Bruising		
Fatigue			Coughing Up Blood			Gums Bleed Easily		
Fever			Shortness of Breath			Enlarged Glands		
Sweats			Wheezing			Prolonged Bleeding		
EYES	Y	N						
Glasses / Contacts								
Eye Pain			*GASTROINTESTINAL*	Y	N	*MUSCULOSKELETAL*	Y	N
Double Vision			Heartburn			Joint Pain/Swelling		
Glaucoma			Nausea / Vomiting			Stiffness		
Cataracts			Constipation			Muscle Pain		
EAR, NOSE, THROAT	Y	N	Change in Bowel Habits			Back Pain		
Difficulty Hearing			Diarrhea			*SKIN*	Y	N
Ringing in Ears			Difficulty Swallowing			Rash/Sores		
Vertigo			Jaundice			Itching/Burning		
Sinus Trouble			Abdominal Pain			*NEUROLOGICAL*	Y	N
Nasal Stuffiness			Dark / Black Stool			Seizures		
Frequent Sore Throat			*GENITOURINARY*	Y	N	Weakness/Paralysis		
Hoarseness			Pain Urinating			Numbness		
CARDIOVASCULAR	Y	N	Burning			Tremors		
Murmur			Frequency			Memory Loss		
Chest Pain			Nighttime			*ENDOCRINE*	Y	N
Palpitations			Blood in Urine			Loss of Hair		
Dizziness or Fainting Spells			Difficulty Urinating			Heat/Cold Intolerance		
Shortness of Breath			History of Kidney Stone			Change in Nails		
Difficulty Lying Flat			History of STD			*IMMUNOLOGICAL*	Y	N
Swelling Ankles / Other			Abnormal Discharge			Hay Fever / Asthma		
						Hives / Eczema		
FEMALE ONLY	Y	N	*FEMALE ONLY*	Y	N	*PHYCHIATRIC*	Y	N
Are you pregnant			Date of last period:			Anxiety / Depression		
Number of pregnancies:			Number of live births:			Mood Disorder		
Are Menstrual Periods Regular			Menopause					
Recent Vaginal Bleeding			Recent Vaginal Discharge					
Do you take birth control pills			Do you take hormones					

Please list additional health information you feel may be important to your physician:

_____

_____

_____

_____

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