Oncology Consultants
Overcoming Cancer.™

# PLEASE READ BEFORE FILLING OUT FORMS:

**All signatures will be completed AT the doctor's office.**

## Option 1

Instructions for download and office submission

1) Print the forms and fill out using a pen.
2) OR Fill out forms on your computer and print.
3) Bring your filled out forms with you to your appointment.
4) You will not "SIGN" the forms until you come in for your appointment.

## Option 2

Instructions for secure electronic form submission

1) Download the form onto your computer.
2) **SAVE** the file before filling out.
3) Once completed, click the gray submit button on the last page. The form will be sent to our HIPPA secure site for processing by our new patient team.
4) You will NOT sign the form until you come in for your appointment.

**For any questions regarding the forms,**
**Please contact our new patient team at:**
**1-888-827-9525.**

Name_____ Date of Birth_____

Do you have any known allergies?

- ○ No
- ○ Yes

If yes, list all allergies including the year or your age when you learned of each allergy

☐ **Medicines & supplements** (prescription or over the counter)

| Drug Name | Reaction/Severity | Date | Age |
|---|---|---|---|
| | | | |
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☐ **Foods & Environment**

| Name | Reaction/Severity | Date | Age |
|---|---|---|---|
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**Adult Vaccines**: Have you had any vaccinations for diseases in the last 10 years?

- ☐ Flu vaccine When:_____
- ☐ Herpes Zoster Vaccine When:_____
- ☐ Pneumonia Vaccine When:_____
- ☐ Other , details _____

Please check any health issues which you either have currently, or have had in the past:

**General Health Issues**

- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain
- ☐ Change in appetite
- ☐ Fevers and / or chills
- ☐ Sweats

- [ ] Difficulty sleeping
- [ ] Other: _____

**Heart and circulation Issues**

- [ ] High blood pressure
- [ ] Chest pain
- [ ] Irregular heart rate
- [ ] Palpitations
- [ ] Heart attack
- [ ] Swelling of ankles or legs
- [ ] Stroke
- [ ] Blood clot
- [ ] Other:

_____

**Lung or breathing issues:**

- [ ] Shortness of breath
  - [ ] At rest
  - [ ] With exercise
- [ ] COPD (chronic obstructive pulmonary disease)
- [ ] Asthma
- [ ] Emphysema
- [ ] Cough
  - [ ] Producing sputum or phlegm
  - [ ] Dry cough
- [ ] Wheezing
- [ ] Pneumonia
- [ ] TB
- [ ] Other: _____

Digestive issues:

- [ ] Heartburn
- [ ] Indigestion
- [ ] Ulcers
- [ ] Swallowing problems
- [ ] Nausea or vomiting
- [ ] Vomiting blood
- [ ] Abdominal cramping or pain
- [ ] Diarrhea

- ☐ Gas
- ☐ Blood in stool
- ☐ Hepatitis
- ☐ Yellow eyes or skin
- ☐ Other: _____

**Urinary issues:**

- ☐ Painful urination
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Frequent urination
- ☐ Bladder infections
- ☐ Kidney disease
- ☐ Kidney failure
- ☐ Other: _____

**Men Only:**

- ☐ Trouble passing urine
- ☐ Enlarged prostate
- ☐ Erectile dysfunction
- ☐ Birth control status
  - ☐ Method(s) currently used:_____
  - ☐ Not sexually active
- ☐ Other: _____

**Women Only:**

- ☐ Age at first menses _____
- ☐ Age or date of last menses _____
- ☐ Pregnancy history
  - ☐ Number of pregnancies _____
  - ☐ Number of live births _____
  - ☐ Interrupted pregnancies _____
- ☐ Date or age at most recent PAP smear _____
- ☐ Date of most recent Mammogram: _____
  - ☐ Never had mammogram

Premenopausal women:

- ☐ Cycle length _____ Regular cycles ◯ Yes ◉ No
- ☐ Duration of flow _____days

- ☐ Birth control method currently used
  - ☐ None
  - ☐ Tubal ligation Date or age:_____
  - ☐ Birth control pill
  - ☐ Birth control patch
  - ☐ Implant
  - ☐ Condom or diaphragm
  - ☐ IUD
  - ☐ Partner with vasectomy
  - ☐ Other:_____
- ☐ Not sexually active or at risk for pregnancy

Post-Menopausal women:

- ☐ Age at menopause: _____
- ☐ Cause of menopause
  - ☐ Natural
  - ☐ Ovaries removed, date or age:_____
- ☐ Hormone replacement therapy, past or present
  - ☐ None used
  - ☐ HRT started date or age:_____
  - ☐ Medication used:_____
  - ☐ Last dose of HRT at age / date:_____

**Blood issues:**

- ☐ Bleeding problems
- ☐ Easy bruising
- ☐ Blood clot
- ☐ Anemia
- ☐ Prior blood transfusions
  - ☐ When:_____
  - ☐ Reason:_____
- ☐ Other: _____

**Nervous system issues:**

- ☐ Memory changes
- ☐ Ringing in ears
- ☐ Pain
  - ☐ Where:_____

- [ ] Started when:_____
- [ ] Tremors
- [ ] Numbness
- [ ] Headaches
- [ ] Seizure
- [ ] Blurred vision
- [ ] Paralysis
- [ ] Loss of coordination
- [ ] Other: _____

**Bone and Joint issues:**

- [ ] Painful joints
- [ ] Swollen joints
- [ ] Muscle pain
- [ ] Muscle cramping
- [ ] Osteoporosis
- [ ] Other: _____

**Endocrine issues:**

- [ ] Diabetes
  - [ ] Insulin
  - [ ] Oral medication
  - [ ] Diet control
- [ ] Thyroid problems
- [ ] Enlarged thyroid
- [ ] Nervousness
- [ ] Hair loss or thinning
- [ ] Heat or cold intolerance
- [ ] Hot flashes
- [ ] Other: _____

**Skin issues:**

- [ ] Eczema
- [ ] Moles
- [ ] History of melanoma
- [ ] History of skin cancer
- [ ] Open wound
- [ ] Other: _____

**Emotional well being:**

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Mood swings
- ☐ Psychiatric problems _____
- ☐ Other: _____

**Infection history: Have you ever had any of the following diagnosed?**

- ☐ Chicken pox
- ☐ Shingles
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ HPV

| Other Health problems | Date | Age |
|---|---|---|
| | | |
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| Past Surgeries | Date | Age |
|---|---|---|
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**Family History: Do you have any immediate relatives who have been diagnosed with cancer or blood diseases?**

- ☐ **Mother**
  - ☐ Cancer at age:_____
    - ☐ Breast
    - ☐ Ovary

- ☐ Colon
- ☐ Cervix
- ☐ Lung
- ☐ Other

☐ Blood disease

- ☐ Anemia
- ☐ Blood clot
- ☐ Stroke

☐ **Father**

☐ Cancer at age:_____

- ☐ Colon
- ☐ Prostate
- ☐ Lung
- ☐ Other

☐ Blood disease

- ☐ Anemia
- ☐ Blood clot
- ☐ Stroke

☐ **Sister**

☐ Cancer at age:_____

- ☐ Breast
- ☐ Ovary
- ☐ Colon
- ☐ Cervix
- ☐ Lung
- ☐ Other

☐ Blood disease

- ☐ Anemia
- ☐ Blood clot
- ☐ Stroke

☐ **Brother**

☐ Cancer at age:_____

- ☐ Colon
- ☐ Prostate
- ☐ Lung

- ☐ Other
- ☐ Blood disease
  - ☐ Anemia
  - ☐ Blood clot
  - ☐ Stroke

☐ **Maternal Grandmother**

- ☐ Cancer at age:_____
  - ☐ Breast
  - ☐ Ovary
  - ☐ Colon
  - ☐ Cervix
  - ☐ Lung
  - ☐ Other
- ☐ Blood disease
  - ☐ Anemia
  - ☐ Blood clot
  - ☐ Stroke

☐ **Paternal Grandmother**

- ☐ Cancer at age:_____
  - ☐ Breast
  - ☐ Ovary
  - ☐ Colon
  - ☐ Cervix
  - ☐ Lung
  - ☐ Other
- ☐ Blood disease
  - ☐ Anemia
  - ☐ Blood clot
  - ☐ Stroke

☐ **Maternal Grandfather**

- ☐ Cancer at age:_____
  - ☐ Colon
  - ☐ Prostate
  - ☐ Lung
  - ☐ Other

- ☐ Blood disease
  - ☐ Anemia
  - ☐ Blood clot
  - ☐ Stroke

☐ **Paternal Grandfather**

- ☐ Cancer at age:_____
  - ☐ Colon
  - ☐ Prostate
  - ☐ Lung
  - ☐ Other
- ☐ Blood disease
  - ☐ Anemia
  - ☐ Blood clot
  - ☐ Stroke

**Do you have any cousins, aunts, or uncles with a history of:**

- ☐ Cancer
  - ☐ Colon
  - ☐ Breast
  - ☐ Ovary
  - ☐ Lung
  - ☐ Prostate
- ☐ Blood diseases
  - ☐ Stroke
  - ☐ Blood clot
  - ☐ Other

**Social History:**

1. **Smoking status:**
   - ☐ **Never Smoked**
   - ☐ **Active smoker**
     - ☐ **Number of years smoking: _____**
     - ☐ **Packs per day: _____**
       - ☐ **More than 10 cigarettes / day**
       - ☐ **Less than 10 cigarettes / day**
     - ☐ **Tobacco Products used**
       - ☐ **Cigarettes**

- ☐ Cigars
- ☐ eCigarettes or Vapor cigarettes
- ☐ Chewing tobacco
- ☐ Other:_____

☐ Former Smoker

- ☐ Stopped smoking Year: __ _____ or at age:_____
- ☐ Number of years smoking: _____
- ☐ Packs per day: _____
  a. More than 10 cigarettes / day
  b. Less than 10 cigarettes / day

2. Alcohol consumption

☐ Never consumed alcoholic beverages

☐ Yes, current every day drinker

- ☐ Number of drinks per day:_____
- ☐ Type of alcohol consumed: _____

☐ Yes, current occasional drinker

- ☐ Number of days per week:_____
- ☐ Number of drinks per week:_____
- ☐ Type of alcohol consumed: _____

☐ Former alcohol drinker, but have stopped

- ☐ Years quit: _____ or Date quit:_____

3. Other products or substances used

☐ Never used other drugs or products

☐ Current use of other drugs or products:_____

☐ Former use of other drugs or products:

- ☐ Stopped use Year: _____ or age:_____
- ☐ Products used:_____

4. Support systems:

☐ Marital Status

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed

☐ I live

- ☐ Alone
- ☐ With my spouse or partner

- ☐ With family
- ☐ With friend / roommate
- ☐ In an assisted living community

☐ I have transportation concerns that may make it difficult to attend my appointments

- ☐ No
- ☐ Yes:_____

**Activity and Nutrition:**

1. **My normal activity can be described as**
   - ☐ Sedentary
   - ☐ Daily activities, including walking and movement
   - ☐ Occasional light exercise
   - ☐ Regular exercise
   - ☐ Extensive exercise routine
2. **My food or nutrition program can be described as**
   - ☐ Regular meals, no restrictions
   - ☐ Vegetarian diet
   - ☐ Vegan diet
   - ☐ Daily use of nutritional supplements
   - ☐ Liquid or pureed food only
   - ☐ Tube feedings or supplements
   - ☐ Other food restrictions: _____

**Current Medication list**

| Medication Name | Strength | Number taken per day | Reason taking medication | Start date or age | Ordering MD |
|---|---|---|---|---|---|
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**Submit Form to Oncology Consultants**