



BUX-MONT ONCOLOGY HEMATOLOGY MEDICAL ASSOCIATES, P.C.

Medical Oncology • Hematology

New Patient Initial Evaluation Form

Date: _____

Dear New Patient,

WELCOME TO OUR PRACTICE. Please fill out the information found below to the best of your ability.

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Diagnosis/Reason for Visit: _____

Referred by Doctor (name, address, phone): _____

Family Doctor (name, address, phone): _____

Pharmacy you typically use: _____ Telephone Number: _____

Are you or could you be Pregnant? YES / NO

CURRENT MEDICATIONS (Including dose and frequency):

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

ALLERGIES (Including reaction if known): _____

PAST MEDICAL HISTORY

Have you been diagnosed with any of the following (in past or current medical condition):

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart disease | What Type? _____ | |
| <input type="checkbox"/> Cancer | What Type? _____ | |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Oral gum / bone problem | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Manic-depressive disorder | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> AIDS or HIV + | <input type="checkbox"/> Anemia | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Osteoporosis | | |
| <input type="checkbox"/> Other (please add) | _____ | _____ |

PAST SURGICAL HISTORY

List all surgeries (continue on reverse if necessary):

<i>Procedure</i>	<i>Date(s)</i>
_____	_____
_____	_____
_____	_____

List any other medical conditions you have had, and dates (do not include common cold or flu):

<i>Illness</i>	<i>Date(s)</i>
_____	_____

SOCIAL HISTORY

Occupation: _____ • Retired? Y / N

Chemical or other environmental exposures: _____

Marital Status Single Married Separated Divorced Widowed

Use of Alcohol Never Rare (< 1/wk) Moderate (> 1/wk) Daily (drinks per day=_____)

Use of Tobacco Never quit current smoker
packs per day _____ If quit when? _____ years smoked _____

FAMILY HISTORY

Is there any Family History of **Cancer**? Please specify who and what type of cancer:

IF your family has a history of any of the following, please:

a. Circle the condition and

b. Write 'F' for father, 'M' for mother, 'S' for Sister, and 'B' for Brother within the (): _____

- | | | |
|--------------------------------|-------------------------------|----------------------|
| () Blood Clots | () Bleeding | () Iron Overload |
| () Heart disease | () Kidney problems | () Stroke |
| () Alcoholism | () High blood pressure | () Diabetes |
| () Obesity | () Depression | () Schizophrenia |
| () Early senility | () Manic-depressive disorder | () Seizure disorder |
| () Other (please list): _____ | _____ | _____ |
-

GYNECOLOGIC HISTORY (Women Only)

Date of last Menstrual Period _____ Number of pregnancies _____

Method of Birth Control, if any _____ Number of children born _____

Age that Periods began _____ Number of abortions _____ miscarriages _____

Age Menopause/Change of life _____ Your age when your first child was born _____

Have you ever used birth control pills, fertility drugs, or hormone replacement after menopause?

Please explain: _____

ROUTINE HEALTH MAINTENANCE

List if and when you had the following health maintenance testing done:

- | | |
|---|-----------------------------|
| <input type="checkbox"/> Colonoscopy (Y / N) | When was most recent: _____ |
| <input type="checkbox"/> Mammogram (Y / N) | When was most recent: _____ |
| <input type="checkbox"/> Pap Smear (Y / N) | When was most recent: _____ |
| <input type="checkbox"/> PSA Blood test (Y / N) | When was most recent: _____ |

REVIEW OF SYSTEMS (Please circle any that apply)

GENERAL INFORMATION

Recent weight change
L(*Specify gain or loss)
Loss of appetite
(Persistent) fevers
Sweats at night
Enlarged Lymph nodes

NEUROLOGIC

Headaches
Dizziness/Blackouts
Seizures
Numbness or tingling
Weakness or paralysis
Visual problems
Hearing problems

CHEST

Pain
Shortness of Breath
Cough
Coughing up blood

MOUTH / THROAT:

Pain or soreness
Non-healing lesions
Shifting teeth
Change in fit of dentures
Change in voice
Trouble in swallowing
Neck Mass
Ear pain

GASTROINTESTINAL:

Abdominal or pelvic pain
Nausea, vomiting
Vomiting of blood
Diarrhea
Constipation
Recent bowel changes
Rectal bleeding or Black Stools
History of Diverticulitis or Colitis
Yellow jaundice

MUSCULOSKELETAL:

Back pain
Bone Pain
Swelling of an extremity

GENITOURINARY:

Urinary frequency
Urinating pain
Urinary burning

WOMEN ONLY:

Vaginal Discharge
Breast Lump or mass
Breast pain

MEN ONLY:

Prostate Problem
Penile Discharge
Swollen Testicle

Patient's signature

Nurse or Physician's signature

Updated 3/08/2007