

CHESAPEAKE ONCOLOGY - HEMATOLOGY ASSOCIATES, P.A.
MEDICAL DATABASE FORM

Please fill out this questionnaire to the best of your knowledge. Thank you.

PATIENT INFORMATION			
Today's date:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	Last name:	First: Middle:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Age:	Birth date (mm/dd/yyyy):	
Primary Care Physician (PCP):	Office Address:	Office Phone/Fax:	
Referring Physician:	Office Address:	Office Phone/Fax:	

PAST MEDICAL HISTORY	
(List conditions, illnesses, diagnoses)	
Problem	Comments, dates, details
1.	
2.	
3.	
4.	
5.	
6.	
7.	

SURGICAL HISTORY			
Type of surgery	Year	Reason	Surgeon/Hospital
1.			
2.			
3.			
4.			
5.			
6.			
7.			

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SOCIAL HISTORY				
Employment history:				
Asbestos history:				
Tobacco history:	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	# packs/day	Year start/quit	Total duration
Alcohol history:	Do you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No	# Drinks/day	Other	
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			

MEDICATIONS			
Name	Dose	# per day	Reason for drug
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
Medication allergies		List medications:	Reaction, if any:
Previous blood transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No		Year

FAMILY HISTORY (List medical diagnoses of blood relatives)			
Relation	Age	State of health	If deceased, cause of death and age
Mother			
Father			
Brother #1			
Brother #2			
Brother #3			
Sister #1			
Sister #2			
Sister #3			
Child #1			
Child #2			
Child #3			

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REVIEW OF SYSTEMS							
(Please check EACH item)							
	Yes	No	Year(s)		Yes	No	Year(s)
Drenching night sweats				Dizziness			
Recurrent fevers				Heaviness of arm or leg			
Weight loss (____lbs.)				Depression			
Loss of appetite				Anxiety			
Fatigue				Insomnia			
Headache (frequent)				Seizures			
Eye trouble				Nose bleeds			
Ear, nose, throat trouble				Easy bruising			
Sinus trouble				Enlarged glands (nodes)			
Problems swallowing				Painful urination			
				Frequent urination			
Cough				Blood in urine			
Cough with blood				Joint pains			
Shortness of breath				Back pains			
Chest pains				Rash/itch			
Irregular heart beat				Jaundice			
Leg swelling				Hemorrhoids			
Early satiety				Bleeding from rectum			
Indigestion (GERD)				Black, tar-like stools			
Nausea or vomiting				Diarrhea or constipation			
Vomiting blood				<i>Other</i>			
WOMEN ONLY				MEN ONLY			
	Yes	No	Year(s)		Yes	No	Year(s)
Did you breastfeed?				Decreased urine stream			
Mammograms				Wake at night to urinate			
Breast biopsy							
Excessive menstrual bleeding							
Age @ onset of periods:							
Last menstrual period (date or age):							
Number of pregnancies:							
Age when first child delivered							
Oral contraceptive use?							
Hormone replacement?							

PLEASE ADD ANY COMMENTS BELOW