Pacific Shores MEDICAL GROUP
Hematology · Oncology · Infusion Services
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Treating Physician: Clinic:
Date: Account #:
Patient Name: DOB: Age: Gender:

Please fill out ALL 6 of the attached pages to the best of your ability. The Doctor or staff member will be reviewing this form with you.

Date of First Visit: _____

CHIEF COMPLAINT, REASON FOR THIS VISIT:(Please write down date it started, duration, tests, and treatments you have had):_____

PERSONAL PAST MEDICAL HISTORY
(Check all that apply)

____Cancer ____Lung Disease ____Heart Disease
____Anemia ____Emphysema ____Liver Disease
____Diabetes ____Asthma ____Neurologic
____Arthritis ____Chronic Bronchitis
____Kidney Disease ____High Blood Pressure
____ Other

Please explain:_____

SURGERIES AND HOSPITAL ADMISSIONS
(Please indicate type of surgery or reason for hospitalization, date, hospital and duration):

ACCIDENTS/INJURIES (Such as falls, physical abuse, car accidents). Please explain:_____

FAMILY HISTORY: Please indicate if any of your family members (blood relatives) have or have had **CANCER**.

Relative	Type of cancer	Age found	Outcome

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FAMILY HISTORY: (Continued)

Hemophilia/Bleeding Disorders: _____
Diabetes Mellitus: _____
High blood pressure: _____
Emotional/Psychiatric: _____
Other diseases: _____

SOCIAL HISTORY:

Smoking:

Never **Pipe** **Cigars**
____Cigarettes **____Second hand smoke**
Amount _____ Duration in years_____
If quit, when_____

Alcohol intake:

____Never ____Occasional ____Social
Frequent
Drinks per week: ____0-3 ____3-7 ____7-14
____14-21 ____more than 21
Drinks to intoxication:
____ Never ____Rare ____ Frequent

Drug abuse: Yes ____ No If Yes,
describe:_____

Do you have a **durable power of attorney**?
___Yes ___No If Yes, **please provide us with a copy.**

Do you have a next of kin or person who will make decisions for you if needed? Yes ____No
If Yes, give **name and phone number**, and explain relationship: _____

Hobbies:_____

Ethnic Extraction Please check one or more categories that describe you: ____Black/African American
____Asian ____American Indian/Alaska Native
____Caucasian ____Native Hawaiian/Pacific Islander
____Other (specify)_____
Are you Hispanic or Latino? ____Yes ____No

Preferred Language:_____
Religion: _____

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MARITAL STATUS:

____ single ____ married ____ widowed ____divorced
____other _____
Do you have **children**? ____ Yes ____ No
If Yes, how many / ages
_____
Do you have any **brothers**? ____ Yes ____ No
If Yes, how many / ages _____
Do you have any **sisters**? ____ Yes ____ No
If Yes, how many / ages _____
_____

Living conditions / arrangements:

____home ____apartment ____nursing home
____other _____
Describe who else lives with you:
_____

WORKING STATUS:

____working ____retired ____unemployed
____disabled
____other_____
Type of work if applicable: _____
_____
If retired, previous occupation(s):_____
_____

MEDICATIONS / DRUG ALLERGIES

(IMPORTANT: Do not write your medications here. Please make sure to fill out the medication list form provided separately)

IMMUNIZATIONS:

Pneumovax: ____Yes ____No Date:_____
Flu: ____Yes ____No Date:_____
Hepatitis B: ____Yes ____No Date:_____
Tetanus: ____Yes ____No Date:_____
Other:_____
_____

DIET: Are you on any special diet?

____Yes ____No
If Yes, please describe your diet._____
_____
_____

DIETARY SUPPLEMENTS:

Are you on any food supplements?
____Yes ____No
If Yes, please describe_____
_____

GENERAL/CONSTITUTIONAL:

____fatigue ____chills ____sweats
____weight loss ____fever ____lack of appetite
____explain_____

Height_____ Current Weight_____lbs
Usual weight (before illness) _____ lbs
Maximum weight _____ lbs

RESPIRATORY:

____cough ____emphysema ____pneumonia
____chest pain ____shortness of breath
____asthma ____coughing up blood
____ wheezing ____chronic bronchitis
____pleurisy ____tuberculosis ____sputum
____occupation exposure (such as asbestos)
____explain_____

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ALLERGIC/IMMUNOLOGIC:
___hay fever ____asthma ____immune deficiency
____explain_____

Date of last chest x-ray:
Where:
Result:

SKIN/HAIR/NAILS:
____bleeding ____sores ____scaling
____rash ____hives ____changing moles
____itching ____cancer ____easy bruising
____hair loss ____ulcers ____discoloration of nails
____explain_____

BREASTS:
____pain ____nipple discharge ____redness
____lump ____nipple retraction ____cyst
____infection ____biopsy ____swelling
____surgery ____previous radiation treatment
____explain_____

HEAD AND NECK:
____headache ____pain ____lump
____migraine ____stiffness
____explain_____

Date of last mammogram:_____
Where:_____
Result:_____

MOUTH AND THROAT:
__pain ____dryness ____difficulty
____soreness ____tooth ache swallowing
____sore gums ____dentures ____periodontal
____ulcers ____cavities gum disease
____infection ____hoarseness
____explain_____

CARDIAC:
coronary disease ____myocardial infarction
____chest pain (angina) (heart attack)
____leg swelling ____palpitations (heart
____heart murmur racing)
____congestive heart failure
____hypertension (high blood pressure)
____shortness of breath with minor exertion
____explain_____

NOSE:
_discharge ____bleeding ____obstruction
____dryness ____pain
____explain_____

VASCULAR:
blood clots ____poor circulation
____ ulcers ____ claudication (leg pain while
____varicose veins walking)
____explain_____

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EYES:
____glasses ____redness ____poor vision
____contacts ____pain ____double vision
____itching ____infection ____cataracts
____explain_____

ABDOMEN:
____nausea ____constipation ____ vomiting
____hemorrhoids ____black or bloody stools
____pain ____liver disease ____vomiting blood
____cramps ____cirrhosis ____jaundice
____hernia ____incontinence of stools
____diarrhea ____hepatitis
____recent change in frequency of bowel movements
____explain_____

GYNECOLOGIC: (women only)
____bleeding ____venereal disease ____itching
____spotting ____discharge
____use of contraceptives
____explain_____

Age of first menstrual period_____yrs
Date of last menstrual period_____
Average duration of menstruation (days)_____
Average duration between menstruations (days)____
Removal of ovaries ? ____Yes ____ No
If Yes, ____One ____ Both Date_____
Hysterectomy?____Yes ____No If Yes, Date_____
#of pregnancies_____ Age of 1st pregnancy _____
#of deliveries_____
Last Pap smear(date)_____ Results_____

HISTORY OF BLOOD TRANSFUSIONS:

Have you ever had a blood transfusion?
____Yes ____No

If Yes, please indicate approximate date and number of transfusions_____
_____
_____

ENDROCINE/METABOLIC:
____diabetes ____goiter (thyroid enlargement)
____weight change ____low thyroid function
____intolerance to heat / cold
____explain_____

MUSCULO-SKELETAL:
____pain ____joint swelling ____stiffness
____arthritis ____tenderness ____fractures
____muscle cramps ____weakness ____backache
____explain_____

NERVOUS SYSTEM:
____syncope ____pain ____loss of memory
____poor strength ____seizures ____tingling
____numbness ____dizziness ____stroke
____tremor ____paralysis
____explain_____

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MALE GENITALIA: (males only) ____pain ____testicular mass (lump) ____ulcer ____swelling ____discharge ____venereal disease ____explain_____ Sexual potency ____Normal ____Diminished ____None	**EMOTIONAL:** ____anxiety ____episodes of disorientation ____depression ____ideas about suicide ____hallucinations ____nervous breakdowns ____difficulty sleeping ____explain_____
KIDNEY, PROSTATE-URINARY: ____stones ____ difficulty urinating ____infection ____blood in the urine ____incontinence ____need to urinate at night ____urinary frequency ____explain_____	**PLEASE WRITE ANYTHING ELSE YOU WANT US TO KNOW:**_____ _____ _____ _____
HEMATOLOGIC: ____anemia ____abnormal blood counts ____fatigue ____enlarged lymph nodes ____bruising ____bleeding ____explain_____	**THIS FORM WAS FILLED OUT BY:** **NAME:** _____

06/12/2009/kjs HB 09/12/2009 AL updated 10/30/09 AL Updated 08/11/2011 kjs Updated 02/08/2012 AL

PATIENT/CAREGIVER INITIALS:_____ **DATE:**_____