Name: _____ DOB: _____

CHESAPEAKE ONCOLOGY HEMATOLOGY ASSOCIATES
PATIENT HISTORY

HISTORY OF PRESENT ILLNESS: Please describe the reason for your visit.

_____
_____

_____
_____

PAST MEDICAL HISTORY: Please list any past or current health problems.

Medical Conditions	Surgeries	Date

SOCIAL HISTORY

Substance	Use?	Type	How Much?	How Often?	How Long?	If quit, when?
Alcohol	◯ No ◯ Yes					
Tobacco	◯ No ◯ Yes					
Caffeine	◯ No ◯ Yes					
Illicit Drugs	◯ No ◯ Yes					

PREVENTATIVE HEALTH MAINTENANCE

Please provide dates for each answer or write "none."	
Last Colonoscopy: _____	Last Flu Vaccine: _____
Last Pneumonia Vaccine: _____	Last COVID Vaccine: _____
Female	**Male**
Last Mammogram: _____	Last Prostate Exam: _____
Last Pap Smear: _____	Last PSA: _____
Last Bone Density: _____	

CARE TEAM: Please list referring physician and any others that you are currently seeing.

Physician/Specialty	Address	Phone Number

Blood Transfusion History:

◯ No ◯ Yes When? _____

Name: _____ DOB: _____

REPRODUCTIVE HISTORY

of pregnancies: _____ # of children: _____ Age at first pregnancy: _____

Last menstrual period: _____ Age at first period: _____ Age at last period: _____

Hysterectomy? ◯ Yes ◯ No Ovaries Removed? ◯ Yes ◯ No

Hormone Use? ◯ Yes ◯ No Oral Contraceptives? ◯ Yes ◯ No

FAMILY HISTORY: Please list any health conditions in your family, including cancers and blood disorders.

Relationship	Condition(s)	Age at Diagnosis	Status
Mother			◯ Alive ◯ Deceased
Father			◯ Alive ◯ Deceased
Sister(s)			◯ Alive ◯ Deceased
Brother(s)			◯ Alive ◯ Deceased
Children			◯ Alive ◯ Deceased
Maternal Grandmother			◯ Alive ◯ Deceased
Maternal Grandfather			◯ Alive ◯ Deceased
Paternal Grandmother			◯ Alive ◯ Deceased
Paternal Grandfather			◯ Alive ◯ Deceased

REVIEW OF SYSTEMS

Constitutional		
Weight Loss	◯ Yes	◯ No
Poor Energy Level	◯ Yes	◯ No
Fever	◯ Yes	◯ No
Chills	◯ Yes	◯ No
Night Sweats	◯ Yes	◯ No

Eyes		
Double Vision	◯ Yes	◯ No
Vision Loss	◯ Yes	◯ No
Flashing Lights	◯ Yes	◯ No

ENT/Mouth		
Ringing in Ears	◯ Yes	◯ No
Hearing Loss	◯ Yes	◯ No
Oral Ulcers	◯ Yes	◯ No
Mouth Pain	◯ Yes	◯ No
Sore Throat	◯ Yes	◯ No
Difficulty Swallowing	◯ Yes	◯ No
Hoarseness	◯ Yes	◯ No

Cardiovascular		
Chest Pain	◯ Yes	◯ No
Palpitations	◯ Yes	◯ No
Fainting Spells	◯ Yes	◯ No
Leg Swelling/Pain	◯ Yes	◯ No
Arm Swelling/Pain	◯ Yes	◯ No

Respiratory		
Cough	◯ Yes	◯ No
Wheezing	◯ Yes	◯ No
Shortness of Breath	◯ Yes	◯ No
Coughing Blood	◯ Yes	◯ No
Pain with Breathing	◯ Yes	◯ No

Breast		
Mass	◯ Yes	◯ No
Pain	◯ Yes	◯ No
Nipple Discharge	◯ Yes	◯ No
Change in Size	◯ Yes	◯ No
Change in Shape	◯ Yes	◯ No

Gastrointestinal		
Nausea	◯ Yes	◯ No
Vomiting	◯ Yes	◯ No
Jaundice	◯ Yes	◯ No
Abdominal Pain	◯ Yes	◯ No
Maroon/Black Stools	◯ Yes	◯ No
Constipation	◯ Yes	◯ No
Diarrhea	◯ Yes	◯ No
Vomiting Blood	◯ Yes	◯ No

Urinary		
Painful Urination	◯ Yes	◯ No
Blood in Urine	◯ Yes	◯ No
Increased Frequency	◯ Yes	◯ No
Loss of Control	◯ Yes	◯ No
Impotence	◯ Yes	◯ No

Gynecological		
Vaginal Discharge	◯ Yes	◯ No
Pelvic Pain	◯ Yes	◯ No
Abnormal Bleeding	◯ Yes	◯ No

Musculoskeletal		
Muscle Pain	◯ Yes	◯ No
Spine Tenderness	◯ Yes	◯ No
Swollen Joints	◯ Yes	◯ No
Joint Redness	◯ Yes	◯ No
Bone Pain	◯ Yes	◯ No

Skin		
Rash	◯ Yes	◯ No
Nodules	◯ Yes	◯ No
Itchiness	◯ Yes	◯ No
Lesions	◯ Yes	◯ No

Neurological		
Confusion	◯ Yes	◯ No
Seizures	◯ Yes	◯ No
Tremors	◯ Yes	◯ No
Speech Change	◯ Yes	◯ No
Headaches	◯ Yes	◯ No
Abnormal Gait	◯ Yes	◯ No
Weakness	◯ Yes	◯ No
Sensory Change	◯ Yes	◯ No

Psychiatric		
Depression	◯ Yes	◯ No
Anxiety	◯ Yes	◯ No
Bipolar	◯ Yes	◯ No

Endocrine		
Excessive Urine	◯ Yes	◯ No
Excessive Thirst	◯ Yes	◯ No
Hot Flashes	◯ Yes	◯ No
Hot/Cold Intolerance	◯ Yes	◯ No

Hematological		
Nose Bleeds	◯ Yes	◯ No
Bleeding Gums	◯ Yes	◯ No
Easy Bruising	◯ Yes	◯ No

Lymphatic		
Enlarged Nodes	◯ Yes	◯ No
Leg/Arm Swelling	◯ Yes	◯ No