

CONTACT INFORMATION

Legal First Name _____ Last Name _____

Preferred Name _____ D.O.B _____

Home Address _____
Street City State Zip

Phone Numbers (H) _____ (C) _____ (W) _____

Email Address _____

Sex Assigned at Birth Male Female Intersex Other please specify: _____ Choose not to disclose

Gender Identity Male Female Non-binary Trans-Male Trans-Female Other

Preferred pronouns He/Him She/Her They/Them Other _____

Race (Select all that apply) Asian Black or African American Latino/ Latina/Latinx Native American or First American

Native Hawaiian and Pacific Islander White Other Race _____ I wish not to disclose

Ethnicity _____ Preferred Language _____

Health Care Providers

Referring Physician _____

Primary Care Physician _____

OB/GYN Physician _____

Other _____

Please list any other physicians you would like to receive copies of information

Name	Problem Cared For
1. _____	_____
2. _____	_____
3. _____	_____

Unless otherwise specified below, prescription medications will be filled at our Medically Integrated Dispensary Office.

Pharmacy Name _____ Phone _____

Address _____

PERSONAL MEDICAL HISTORY

Medications

Please list all current prescriptions and over-the-counter medications. Include herbals, supplements, and vitamins.

Medication	Dosage (ex. mg. ml.)	How often?	When prescribed?

Legal Name _____ D.O.B. ____/____/____

Allergies

Latex Allergy Yes No

Are you allergic to any medications? Yes No If yes, please list the medication and type of reaction:

- 1. _____ 2. _____
- 3. _____ 4. _____

Are you on oxygen? Yes No

Hospitalizations

Please list all hospitalizations.

Date	Reason for Hospitalizations	Where	Doctor

Surgeries/Procedures

Please list all surgeries and procedure details and year occurred (e.g. pacemaker, dental extractions)

Date	Type of Surgery or Procedure	Where	Doctor

Previous Treatment for Cancer (if applicable)

Radiation Therapy _____

Chemotherapy/Immunotherapy/Targeted Therapy _____

Hormone Therapy _____

Blood Transfusions

Have you ever had a blood transfusion? Yes No If yes, did you have a reaction? Yes No

Date of last transfusion _____

Legal Name _____ D.O.B. ____/____/____

Please check if you had or currently have any of the following.

<input type="checkbox"/> Anemia		<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Jaundice/Hepatitis Type:	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Liver/Gallbladder Disease	
<input type="checkbox"/> Blood Disorder/Blood Clots		<input type="checkbox"/> Measles/Mumps/Rubella/Chicken Pox	
<input type="checkbox"/> Bladder Problems		<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Cancer type:		<input type="checkbox"/> Migraine or Frequent Headaches	
<input type="checkbox"/> Chronic Pain		<input type="checkbox"/> Sexually Transmitted Infections (Herpes, HIV)	
<input type="checkbox"/> Colitis/Crohn's Disease		<input type="checkbox"/> Seizure Disorder	
<input type="checkbox"/> Connective Tissue Disease (Lupus)		<input type="checkbox"/> Skin Disease (eczema, psoriasis, hives)	
<input type="checkbox"/> COPD/Emphysema		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Congestive Heart Failure		<input type="checkbox"/> Thyroid Problem	
<input type="checkbox"/> Depression		<input type="checkbox"/> Other medical problems not listed. List below.	
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> Heart Condition (Afib, Heart Attack)			
<input type="checkbox"/> High Blood Pressure			

Exam/Vaccine History

List month/year you last had:

Flu Vaccine _____ Hepatitis Vaccine _____ Pneumonia Shot _____ Tetanus Shot _____
 TB Test (PPD) _____ Eye Exam _____ Dental Visit _____ Stool Blood Test _____
 Rectal Exam _____ Colonoscopy/Sigmoid Exam _____ COVID-19 Vaccine (date of last dose) _____

Assigned Male at Birth Only

Last PSA screening _____ Last prostate exam: _____

Assigned Female at Birth Only

Age at first menstrual period _____ If still menstruating, date of last period _____
 Age at menopause _____ Have you ever taken birth control pills? Yes No If yes, how long? _____Yrs
 Do you currently use birth control? Yes No If yes, what type? _____
 Have you ever taken fertility drug treatments? Yes No
 Have you ever taken hormone replacements? Yes No If yes, how long? _____Yrs
 Are you currently taking hormone replacements? Yes No If yes, what type? _____
 Number of pregnancies _____ Number of live births _____ Age at first childbirth _____
 Did you breastfeed? Yes No If yes, how long? _____
 Have you had a hysterectomy? Yes No If yes, when? _____
 Are your ovaries intact? Yes No If no, when were they removed? _____
 Year of last:
 Pap Test _____ Normal Abnormal Breast Exam _____ Normal Abnormal
 Mammogram _____ Normal Abnormal
 Do you perform monthly self-breast exam? Yes No

Legal Name _____ D.O.B. ____/____/____

SOCIAL HISTORY

Relationship Status Married Single Divorced Widowed Domestic Partner

Living Arrangement Alone With spouse With significant other or roommate

Supervised Living Other _____

Do you have children? Yes No If yes, how many? _____ Are your children: Biological Adopted

Do you have any of the following:

Organ Donor Card Health Care Proxy Power of Attorney Living Will

If you have signed any of these legal documents, please bring copies to your next appointment.

Would you like more information on any of these? Yes No

Do you have Medical Power of Attorney, Living Will, or Out-of-Hospital Do Not Resuscitate Forms? Yes No

Advance Care Planning (ACP) is an ongoing process of learning about the choices we each have for our future medical care.

Would you like more information about Advance Care Planning? Yes No

Is there someone who you would like to list as your primary contact regarding your healthcare? Yes No

Name _____ Relationship _____ Phone _____

Are you currently employed? Yes No Retired

Occupation (previous if retired) _____ Employer _____

Are you a Veteran? Yes No

If yes, Branch _____ Years served _____ Active combat? Yes No Discharge year _____

Do you now or did you ever:

Smoke cigarettes/cigars/pipes/vaping/chewing tobacco? Yes No

If yes, # of pack(s)/day _____ # of yrs _____ When did you quit? _____

Consume alcohol? Yes No

If yes, # of drinks/day _____ Drinks/week _____ When did you quit? _____

Consume cannabis? Yes No

If yes, # times/day _____ # times/week _____ When did you quit? _____

Use illegal drugs? Yes No

If yes, which ones? _____ When did you quit? _____

Do you wear sunscreen? Yes No

Do you follow a specific diet or have any dietary restrictions (i.e., low-sodium, vegan, keto, etc.)? Yes No

If yes, please describe _____

Do you have any food allergies Yes No

If yes, please describe _____

Do you exercise regularly? Yes No

If yes, please describe and how often _____

FAMILY MEDICAL HISTORY

Relative	Alive or Deceased?	Ever diagnosed with Cancer?	Age at Cancer diagnosis	Type of Cancer (breast, lung, colon, etc.)	Other Medical Problem (heart disease, diabetes, etc.)
Biological Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Biological Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Maternal Grandmother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Maternal Grandfather	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Paternal Grandmother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Paternal Grandfather	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Biological Siblings					
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Biological Children					
<input type="checkbox"/> Daughter <input type="checkbox"/> Son	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<input type="checkbox"/> Daughter <input type="checkbox"/> Son	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<input type="checkbox"/> Daughter <input type="checkbox"/> Son	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<input type="checkbox"/> Daughter <input type="checkbox"/> Son	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Additional:					
Other Relatives (ex. cousin, aunt or uncle)					
	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age at death _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

Are you currently experiencing any of the following? Check all that apply in both columns.

CONSTITUTIONAL

- No problems or concerns
- Recent weight loss
- Recent weight gain
- Fevers / chills
- Night sweats
- Excessive itching
- Food supplements

_____ Number of meals daily

EYES

- No problems or concerns
- Glaucoma
- Cataracts
- Vision Loss
- Other: _____

EAR, NOSE, MOUTH, THROAT

- No problems or concerns
- Hearing Loss
- Dental Problem
- Hoarseness
- Nose bleeds
- Other: _____

CARDIOLOGY

- No problems or concerns
- High blood pressure
- Heart Murmur
- Rapid/irregular heartbeat
- Chest pain / tightness
- Pacemaker / Defibrillator
- Ankle swelling
- Leg cramps at night
- Other: _____

RESPIRATORY

- No problems or concerns
- Asthma / Bronchitis/ Emphysema
- Shortness of breath
- Cough that produces blood
- Other: _____

GASTROINTESTINAL

- No problems or concerns
- Loss of appetite
- Heartburn or indigestion
- Stomach pain or discomfort
- Frequent nausea / vomiting
- Recurrent diarrhea
- Constipation
- Bloody stools
- Black, tarry stools
- Difficulty swallowing
- Other: _____

ENDOCRINE

- No problems or concerns
- Thyroid problems
- Blood sugar problems
- Excessive sweating
- Other: _____

Office Use Only



GENITOURINARY

- No problems or concerns
- Difficulty urinating
- Frequent / painful urination
- Recurrent bladder infection
- Vaginal itching / discharge
- Sexual problems
- Blood in urine
- Other: _____

MUSCULOSKELETAL

- No problems or concerns
- Difficulty walking
- Joint aches or stiffness
- Painful legs / feet
- Back ache / pain
- Other: _____

NEUROLOGICAL

- No problems or concerns
- Difficulty concentrating
- Headache
- Dizziness / fainting/ blackouts
- Numbness hands/ feet
- Seizures / convulsions
- Memory changes
- Other: _____

PSYCHOSOCIAL

- No problems or concerns
- Nightmares
- Anxious / nervousness
- Trouble sleeping
- Lonely / depressed
- Work / family problems
- Tire easily
- Other: _____

SKIN / BREAST

- No problems or concerns
- Sores / rashes
- Moles
- Nipple discharge
- Change in breast size
- Lump / pain
- Other: _____

HEMATOLOGIC / LYMPHATIC

- No problems or concerns
- Easy bleeding / bruising
- Anemia or blood problem
- Frequent infections
- Swelling of glands
- Swelling of hands / feet
- Other: _____

ALLERGIC / IMMUNOLOGIC

- No problems or concerns
- Facial swelling
- Tightening of throat
- Hives
- Other: _____

Provider Signature

Date

Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

New York Oncology Hematology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. New York Oncology Hematology does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

New York Oncology Hematology provides:

Free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Compliance Manager

Filing a Grievance

If you believe that New York Oncology Hematology has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Compliance Manager

NYOH Administrative Offices

449 Route 146, Suite 101 | Clifton Park, NY 12065

Phone: (518) 373-3940 | **Fax:** (518) 373-3931

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Compliance Manager is available to help you.

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights:

- **Electronically** through the Office for Civil Rights Complaint Portal:

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

- **By mail or phone:**

U.S. Department of Health and Human Services

200 Independence Avenue, SW | Room 509F, HHH Building | Washington, DC 20201

(800) 368-1019 | (800) 537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

