NYOH New York Oncology Hematology

NEW PATIENT HISTORY FORM

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.

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

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

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	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
Biological Father	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
Maternal Grandmother	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
Maternal Grandfather	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
Paternal Grandmother	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
Paternal Grandfather	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
Biological Siblings					
☐ Brother ☐ Sister	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
☐ Brother ☐ Sister	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
☐ Brother ☐ Sister	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
☐ Brother ☐ Sister	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
Biological Children					
☐ Daughter ☐ Son	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
☐ Daughter ☐ Son	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
☐ Daughter ☐ Son	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
☐ Daughter ☐ Son	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
Additional:					
Other Relatives (ex. cousin, aunt or uncle)					
	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			
	☐ Alive ☐ Deceased Age at death ____	☐ Yes ☐ No ☐ Unknown			

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

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

_____
Provider Signature Date

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: _____