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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |

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

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_____

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: _____