Cancer & Blood
SPECIALISTS OF ARIZONA
A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

Place Label Here

PATIENT MEDICAL HISTORY FORM - FOR OB PATIENTS ONLY

Dear Patient,

Please return completed packet with signature pages to the front desk.

Patient Name: _____

DOB: ____/____/____ **Age**: _____ ❑ **Male** ❑ **Female** **SS#**: _____

Primary Address: _____

City: _____ State:_____ Zip: _____

Home Phone: ❑ Preferred (_____) _____

Cell Phone: ❑ Preferred (_____) _____

Secondary Address: _____

City: _____ State: _____ Zip: _____

May we leave a message on your answering machine / voicemail? ❑ Yes ❑ No

Email Address: _____ May we email you? ❑ Yes ❑ No

Preferred Language: _____

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino

Race: ❑ Native American or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other

Pharmacy Name: _____

Pharmacy Phone # and Cross Streets:_____

(Internal Use Only)

MRN#: _____

Patient Name: _____ **DOB:** _____

Primary Care Physician: _____Phone: _____

Referring Physician (if different): _____Phone: _____

Please list any additional Physicians you see: (Include Phone #):

_____Phone: _____

_____Phone: _____

_____Phone: _____

_____Phone: _____

Emergency Contact Name:

_____

Relationship: _____ Phone: (_____) _____

Employment Status:

❑ Employed/Self Employed ❑ Unemployed ❑ Retired ❑ Disabled

Occupation (or Former Occupation):_____

Name of Employer: _____ Work Phone: (_____) _____

Advanced Directives:

Living Will ❑ Yes ❑ No ❑ Unknown **Durable Power of Attorney** ❑ Yes ❑ No ❑ Unknown

DNR ❑ Yes ❑ No ❑ Unknown

Patient Name: _____ **DOB:** _____

Medical History Have you EVER had any of the following:

❑ Asthma
❑ Psychiatric Disorder/Illness
❑ Cancer
❑ Seizures or Epilepsy
❑ Diabetes
❑ Urinary/Kidney Disorder
❑ Neurological Disorder/Chronic Headaches
❑ Blood Pressure Disorder/Hypertension
❑ Stroke
❑ COPD
❑ Thyroid Disorder
❑ Heart Attack/Heart Disease/Atrial Fib
❑ Arthritis
❑ Pulmonary Embolism/DVT/Blood Clots
❑ Cholesterol Disorder/Hyperlipidemia
❑ Sleep Apnea
❑ Eye Disorder (i.e. Glaucoma)
❑ Other

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____

_____

Surgery History Please list ANY surgeries you have had and the approximate date.

Procedure	Date	Complications

Prior Cancer Treatment Do you currently have cancer? ❑ Yes ❑ No

Type of Cancer	Year Diagnosed	Treatment	Hospital/Doctor's Office Where You Received Treatment
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:

Allergies

Are you allergic to any medications or other substances? ❑ Yes ❑ No Please list allergies and reactions:

_____

_____

Patient Name: _____ **DOB:** _____

Medication List

Medication Name	Dose	Frequency

Do you have additional medications not listed above? ❑ Yes ❑ No If yes, please use the back of this page to list all others.

Health Maintenance

Date of last bone density: _____

Date of last pap smear: _____ Have you ever had an abnormal PAP smear? ❑ Yes ❑ No

If yes, did you receive any treatment? ❑ Yes ❑ No

Date of last mammogram: _____ Was that mammogram normal? ❑ Yes ❑ No

Date of last colonoscopy: _____ Was that colonoscopy normal? ❑ Yes ❑ No

Family Medical History Please indicate any major conditions, including cancers, that your immediate family members have had.

Relative	Condition and Description	Living?	If deceased, at what age?
Mother		Y N	
Father		Y N	
Sibling		Y N	
Sibling		Y N	
Sibling		Y N	
Grandparent		Y N	
Grandparent		Y N	
Other		Y N	

Social History

Do you currently smoke? ❑ Yes ❑ No If no, previously? ❑ Yes ❑ No
Years smoked_____ Packs per day _____

Do you use other tobacco products? ❑ Yes ❑ No Consume Alcohol? ❑ Yes ❑ No If yes, drinks per week: _____

Do you do any drugs (including marijuana)? If yes, what drug and for how long? _____

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

Do you suffer from domestic violence? ❑ Yes ❑ No Do you feel safe at home? ❑ Yes ❑ No

Patient Name: _____ **DOB:** _____

Pregnancy History

Number of pregnancies: _____ Number of C-Section deliveries:_____ Number of abortions: _____

Number of miscarriages:_____ Number of vaginal deliveries: _____

GYN History

Age of first period: _____ Do you have monthly periods? ❑ Yes ❑ No

Are your periods regular? ❑ Yes ❑ No How often? How many days? _____

Date of last menstrual period: _____

Have you received an HPV vaccine series? ❑ Yes ❑ No If yes, when?_____

Have you had any genetic testing? ❑ Yes ❑ No If yes, when?_____

Are you taking or have you taken hormone replacement therapy? ❑ Yes ❑ No

Age at menopause: _____

Sexual History:

Do you have a partner? ❑ Yes ❑ No ❑ Male ❑ Female

Patient Name: _____ **DOB:** _____

Review of Systems Please indicate ALL that you have experienced within the last 6-12 months.

General

❑ None ❑ Feeling Tired ❑ Fever ❑ Weight Gain
❑ Chills ❑ Weight Loss ❑ Feeling Poorly

Eyes

❑ None ❑ Dry Eyes ❑ Eye Pain ❑ Itchy Eyes
❑ Vision Changes ❑ Eyesight Problems

Ear/Nose/Throat

❑ None ❑ Earache ❑ Loss of Hearing ❑ Nose Bleeds
❑ Sinus Problems ❑ Sore Throat ❑ Hoarseness

Heart

❑ None ❑ Chest Pain ❑ Palpitations ❑ Slow Heart Rate
❑ Leg Swelling ❑ Fast heart rate ❑ Leg pain, discomfort or fatigue during walking

Lungs/Breathing

❑ None ❑ Cough ❑ Wheezing ❑ Shortness of Breath
❑ Trouble breathing with exertion ❑ Trouble breathing when lying flat

Gastrointestinal

❑ None ❑ Abdominal Pain ❑ Constipation ❑ Diarrhea
❑ Heartburn ❑ Nausea ❑ Vomiting ❑ Blood in stool

Skin

❑ None ❑ Acne ❑ Itching ❑ Change in mole
❑ Skin Lesions ❑ Skin Wound ❑ Breast Lump

Neurological

❑ None ❑ Limb Weakness ❑ Confused ❑ Loss of Memory
❑ Convulsions ❑ Headaches ❑ Dizziness ❑ Difficulty Walking

Psychiatric

❑ None ❑ Suicidal ❑ Anxiety ❑ Disturbed Sleep
❑ Depression ❑ Emotional Problems ❑ Change in Personality

Endocrine

❑ None ❑ Hair Loss ❑ Weak Muscles ❑ Hot Flashes
❑ Feeling Weak ❑ Deepening Voice

Hem/Lymph

❑ None ❑ Easy Bleeding ❑ Easy Bruising ❑ Swollen Glands

Patient Name: _____ **DOB:**_____

CONSENT TO DISCLOSE MEDICAL INFORMATION

Please check one of the following:

_____ **I give permission to the employees of Cancer & Blood Specialists of Arizona (CBSA/AOP), a division of American Oncology Partners, P.A. to disclose my Protected Health Information to me and the following individual(s):**

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

_____ I request that all my Protected Health Information be disclosed ONLY to me and no other **individual(s)**.

I understand that I may revoke or change this Consent at any time by filling out another Consent form to replace this one.

_____ _____
Patient Name (Print) Date

_____
Patient or Guarantor (Signature)