Date completed:_________

CHESAPEAKE ONCOLOGY HEMATOLOGY ASSOCIATES, P.A.

http://COHAmed.org

Please fill out to your best knowledge; this will greatly help the doctor

Last Name	First Name MI			Phone# (H)
Phone# (Cell, Work)	Age	Sex	Marital Status	Date of Birth
Home Address				Pharmacy name, number:
Referring/Primary Care MD:	Doctor's Phone, Fax #'s: **FAX TEL**			Patient's Email:

PAST MEDICAL HISTORY: (List conditions, illnesses, diagnoses)

Problem	Comments, dates, details
1	
2	
3	
4	
5	
6	
7	

SURGICAL HISTORY: (List type, reason, surgeon, year, hospital: if known)

1	5
2	6
3	7
4	8

FAMILY HISTORY: (List medical diagnoses of blood relatives)

Relation	Age	State of health	If deceased, cause of death and age.
Mother			
Father			
Brother#1			
Brother#2			
Brother#3			
Sister #1			
Sister #2			
Sister #3			
Child #1			
Child #2			
Child #3			

Date completed:_________

SOCIAL HISTORY

Employment history				
Asbestos history				
Tobacco history	Year started	Year quit	# packs/day	Never smoked
				☐
Alcohol history	# Drinks/day		Alcohol type	Social drinking only
				☐
Married: ☐ Yes ☐ No	**Children:**			

REVIEW OF SYSTEMS:

(Please check ***each*** item)

	NO	YES	YEAR		NO	YES	YEAR
Drenching night sweats	☐	☐		Dizziness	☐	☐	
Recurrent fevers	☐	☐		Heaviness of arm or leg	☐	☐	
Weight loss (#)	☐	☐		Depression	☐	☐	
Loss of appetite	☐	☐		Anxiety	☐	☐	
fatigue	☐	☐		Insomnia	☐	☐	
Headache (frequent)	☐	☐		Seizures	☐	☐	
Eye trouble	☐	☐		Nose bleeds	☐	☐	
Ear, nose, throat trouble	☐	☐		Easy bruising	☐	☐	
Sinus trouble	☐	☐		Enlarged glands (nodes)	☐	☐	
Problems swallowing	☐	☐		Painful urination	☐	☐	
Pain with swallowing	☐	☐		Frequent urination	☐	☐	
Cough	☐	☐		***WOMEN ONLY***			
Cough with blood	☐	☐		Age @ onset of periods____	☐	☐	
Shortness of breath	☐	☐		Number of children____	☐	☐	
Chest pains	☐	☐		Number of pregnancies____	☐	☐	
Irregular heart beat	☐	☐		Breast feeding	☐	☐	
Leg swelling	☐	☐		Excessive menstrual bleeding	☐	☐	
Early satiety	☐	☐		Breast biopsy(s)	☐	☐	
Indigestion (GERD)	☐	☐		Mammograms(s)	☐	☐	
Nausea & vomiting	☐	☐		***MEN ONLY***			
Vomiting blood	☐	☐		Decreased urine stream	☐	☐	
Jaundice	☐	☐		Wake at night to urinate	☐	☐	
Hemorrhoids	☐	☐		Wake to urinate #____times	☐	☐	
Bleeding from rectum	☐	☐		Decreased erections	☐	☐	
Black, tarry stools	☐	☐		Decreased libido	☐	☐	
Constipation	☐	☐		**Special comments**:			
Diarrhea	☐	☐					
Joint pains	☐	☐					
Back pains	☐	☐					
Rash, itch	☐	☐					

Date completed:_________

MEDICATIONS

Name	Dose	# per day	Reason for drug	
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
Medication **Allergies**	Yes ☐ ☐	No ☐ ☐	Reaction, if any	
Previous blood transfusions	Yes ☐	No ☐		Year

Thank you. This information will greatly help your doctor take care of you.
Please add any *comments* below: