CANCER & HEMATOLOGY
CENTERS OF WESTERN MICHIGAN

PATIENT HEALTH INFORMATION

To best care for you, please provide the following information. All information is strictly confidential and is released only with your written consent. Please complete all pages and bring to initial appointment.

Last Name: _____ **First Name:** _____ **M.I.** _____ **Today's Date:** _____

By what name should we call you? _____

Address: _____

Date of Birth: _____ **Phone: ( )** _____ **Email Address:** _____

Preferred Language: _____ **Birth Sex:** _____ **Gender Identity:** _____

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Unknown
- ☐ Decline

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Unknown
- ☐ Decline

Primary Care Provider: _____

Additional Providers: _____

Preferred Pharmacy: _____ **Location:** _____

ALLERGIES

Allergic reaction to? ☐ Latex ☐ Adhesive tape ☐ IV Contrast

If allergic to any of the above, describe reaction: _____

Allergies to any Medications:	**Type of Reaction:**

PAST AND CURRENT MEDICAL CONDITIONS

Have you ever received chemotherapy/immunotherapy?

☐ No ☐ Yes, treatment location: _____

Have you ever received radiation therapy?

☐ No ☐ Yes, treatment location: _____

*Last Name:*_____ *First Name:*_____ *Date:*_____

PAST AND CURRENT MEDICAL CONDITIONS *(CONTINUED)*

Please indicate if you have or have ever had the following:

Y	N		Y	N	
☐	☐	Anemia or Blood Disorder	☐	☐	High Cholesterol
☐	☐	Anxiety	☐	☐	History of Pneumonia (if yes, when? _____)
☐	☐	Arthritis	☐	☐	Irregular Heart Rhythm
☐	☐	Asthma	☐	☐	Kidney Stones
☐	☐	Autoimmune Disorder	☐	☐	Lupus
☐	☐	Blood Clots	☐	☐	Obstructive Sleep Apnea
☐	☐	Blood Transfusions (if yes, when? _____)	☐	☐	Pacemaker
☐	☐	Depression	☐	☐	Previous Cancers
☐	☐	Diabetes (if yes, type? _____)	☐	☐	Rheumatic Fever
☐	☐	Diverticulosis/ Colon Problems	☐	☐	Seizure
☐	☐	Emphysema	☐	☐	Scleroderma
☐	☐	Gallstones	☐	☐	Stroke/TIA
☐	☐	Gastroesophageal Reflux Disease	☐	☐	Thyroid Problems
☐	☐	Heart Attack/ Heart Disease	☐	☐	Tuberculosis (TB)
☐	☐	Hepatitis/ Jaundice	☐	☐	Ulcers
☐	☐	High Blood Pressure	☐	☐	Venous Access Device (if yes, type? _____)

Additional Information: _____

_____

Please list your previous surgeries/procedures (type of surgery/procedure with body part)

Year:	**Surgery and Where Surgery was Completed:**

MEDICATIONS

Please list all medications and supplements you are taking:

Name of Drug:	**Dose:**	**Amount/Frequency per Day:**

*Last Name:*_____ *First Name:*_____ *Date:*_____

HEALTH MAINTENANCE HISTORY

Date of last colonoscopy? _____ / _____/ _____

Date of last bone density (DXA) scan? _____/ _____/ _____

Immunization/Vaccine:	**Month/Day/Year:**

FAMILY HISTORY

If known, complete the below information about your blood relatives. Please include parents, grandparents, great grandparents, aunts, uncles, and siblings. Indicate maternal or paternal.

Relationship to you:	**Type of Cancer:**	**Age at Diagnosis:**	**Cause of Death if Not Cancer:**

Is there any other information you would like us to know about your family? _____

_____

SOCIAL HISTORY

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

Living Arrangement: ☐ With Spouse ☐ Alone ☐ With Child(ren) ☐ Care Facility ☐ Other:_____

Who do you rely on most for help/support? _____

Military service history? ☐ No ☐ Yes

What is/was your occupation: _____

Have you ever used the following:

	TYPE	AMOUNT AND FREQUENCY	LENGTH OF USE	IF STOPPED, WHEN	DO YOU WANT INFORMATION ON STOPPING?
Tobacco					☐ No ☐ Yes ☐ Decline
Alcohol					☐ No ☐ Yes ☐ Decline
Recreation/Street Drugs					☐ No ☐ Yes ☐ Decline

*Last Name:*_____ *First Name:*_____ *Date:*_____

FEMALE HEALTH HISTORY

What age did you start menstruating? _____

Are you post menopausal? ☐ No ☐ Yes Age of onset of menopause? _____

Have you used hormone replacement therapy? ☐ No ☐ Yes Years of use? _____When was it stopped? _____

Date of last Mammogram? _____/ _____/ _____

Number of pregnancies? _____ Number of births? _____ Number of miscarriages? _____

REVIEW OF SYSTEMS

General	**N**	**Y**	**Explain if YES:**
Poor appetite	☐	☐	_____
Decreased energy/fatigue	☐	☐	_____
Generalized weakness	☐	☐	_____
Weight loss	☐	☐	_____
Fever	☐	☐	_____
Drenching night sweats	☐	☐	_____
Hot flashes	☐	☐	_____
Infectious Disorders			
Frequent infection	☐	☐	_____
Severe infection	☐	☐	_____
Hematologic			
Excessive bruising	☐	☐	_____
Spontaneous bleeding	☐	☐	_____
Lymphatic			
Enlarged lymph nodes	☐	☐	_____
Eyes			
Blurred vision	☐	☐	_____
Double vision	☐	☐	_____
Ears, Nose, Mouth, Throat			
Hearing loss	☐	☐	_____
Ringing in ears	☐	☐	_____
Mouth sores	☐	☐	_____
Dry mouth	☐	☐	_____
Heart			
Chest pain/chest pressure	☐	☐	_____
Palpitations	☐	☐	_____
Swelling	☐	☐	_____
Respiratory			
Shortness of breath	☐	☐	_____
Pain with inspiration	☐	☐	_____
Cough	☐	☐	_____
Coughing up blood	☐	☐	_____
Abdomen			
Nausea	☐	☐	_____
Vomiting	☐	☐	_____

Difficulty swallowing	☐	☐	_____
Heartburn	☐	☐	_____
Abdominal pain	☐	☐	_____
Diarrhea	☐	☐	_____
Constipation	☐	☐	_____
Blood in stools	☐	☐	_____
Black stools	☐	☐	_____
Urinary			
Painful urination	☐	☐	_____
Urination during the night	☐	☐	_____
Hesitancy	☐	☐	_____
Urgency	☐	☐	_____
Incontinence	☐	☐	_____
Blood in urine	☐	☐	_____
Frequency	☐	☐	_____
Gynecologic			
Postmenopausal vaginal bleeding	☐	☐	_____
Vaginal dryness	☐	☐	_____
Pain with intercourse	☐	☐	_____
Musculoskeletal			
Muscle pain	☐	☐	_____
Joint pain/stiffness	☐	☐	_____
Back pain	☐	☐	_____
Skin			
Rash	☐	☐	_____
Itching	☐	☐	_____
Lesions/lumps	☐	☐	_____
Neurologic			
Headache	☐	☐	_____
Numbness or tingling	☐	☐	_____
Tremor	☐	☐	_____
Altered consciousness	☐	☐	_____
Seizures	☐	☐	_____
Dizziness	☐	☐	_____
Falls	☐	☐	_____
Psychiatric			
Anxiety	☐	☐	_____
Depression	☐	☐	_____
Thoughts of suicide	☐	☐	_____
Trouble sleeping	☐	☐	_____
Breasts			
Lumps	☐	☐	_____
Tenderness	☐	☐	_____
Discharge/drainage	☐	☐	_____
Skin changes	☐	☐	_____