CHESAPEAKE ONCOLOGY HEMATOLOGY ASSOCIATES, P.A.

http://COHAmed.org

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

Last Name	First Name MI	Best telephone # to reach you:
Referring/Primary Care MD:	Doctor's Phone, Fax #'s: **FAX TEL**	**Pharmacy name, number:**

PAST MEDICAL HISTORY: (illnesses, problems, diagnoses; eg: diabetes, cancer, COPD)

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

SURGICAL HISTORY:

1	**3**
2	4

FAMILY HISTORY: (List medical diagnoses of blood relatives)

Relation	Age	State of health	If deceased, cause of death and age.
Mother			
Father			
Brothers/ sisters			

SOCIAL HISTORY

What type of work do you do? (or have done in the past)				
Tobacco history		Year you started smoking	Year you quit smoking	Never
Alcohol/drugs history		# Drinks/day	Alcohol type	
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	☐	☐	
Indigestion (GERD)	☐	☐		Mammograms(s)	☐	☐	
Nausea & vomiting	☐	☐		***MEN ONLY***			
Vomiting blood	☐	☐		Decreased urine stream	☐	☐	
Jaundice	☐	☐		Wake at night to urinate	☐	☐	
Hemorrhoids	☐	☐		Wake to urinate # times/night	☐	☐	
Bleeding from rectum	☐	☐		Decreased erections	☐	☐	
Black, tarry stools	☐	☐		Decreased libido	☐	☐	
Constipation	☐	☐		**Special comments**:			
Diarrhea	☐	☐					
Joint pains	☐	☐					
Back pains	☐	☐					
Rash, itch	☐	☐					

MEDICATIONS

Name	**Dose**	**# per day**	**Reason for drug**
1			
2			
3			
4			
5			
6			
7			
8			

Please list any medication allergies: