SHENANDOAH ONCOLOGY, P.C. NEW PATIENT HISTORY FORM (please fill out in ink)

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

_____ _____ _____ _____ _____
Referred By DOB Marital Status Height Weight

HISTORY OF PRESENT ILLNESS: Please describe the problem for which you are referred today.

_____

_____

_____

_____

PAST HISTORY: If you need additional space, it is provided on the last page.

Surgeries (with dates)	Medical Conditions

Blood Transfusion History:

Yes No If yes, when? _____

Reproductive History:

Number of pregnancies _____ Number of children: _____ Age at first pregnancy: _____

Age at first period _____ Age at last period: _____

Hysterectomy: Y N Ovaries removed Y N

Hormone use: Y N Oral contraceptive use Y N

Preventive Health Maintenance: Please provide dates for each answer or write "none"

Female		Male	
Last mammogram:		Last colonoscopy:	
Last Pap smear:		Last prostate exam:	
Last colonoscopy:		Last PSA screening:	
Last bone density scan:		Last pneumonia vaccine:	
Last pneumonia vaccine:			

SOCIAL HISTORY

Substance	Do you use?		What Type?	How Much?	How Often?	If quit, when?
Alcohol:	Y	N				
Tobacco:	Y	N				
Caffeine:	Y	N				
Recreational Drugs:	Y	N				

FAMILY HISTORY: **Please list any illnesses in your family including all cancers (i.e. breast cancer, ovarian cancer, etc.) and blood disorders (i.e. anemia, blood clotting disorders, etc.)**

Relationship	Illness	Diagnosis Age	Deceased	Relationship:	Illness	Diagnosis Age	Deceased
Mother:			Y N	Brothers:			Y N
Father:			Y N				Y N
Grandmother (P):			Y N				Y N
Grandfather (P):			Y N	Sisters:			Y N
Grandmother (M):			Y N				Y N
Grandfather (M):			Y N				Y N
				Children:			Y N
							Y N
							Y N

REVIEW OF SYSTEMS

Constitutional		
Weight Loss	Y	N
Poor Energy Level	Y	N
Fever	Y	N
Chills	Y	N
Night Sweats	Y	N

Eyes		
Double Vision	Y	N
Vision Loss	Y	N
Flashing Lights	Y	N

ENT/Mouth		
Ringing in Ears	Y	N
Hearing Loss	Y	N
Oral Ulcers	Y	N
Mouth Pain	Y	N
Sore Throat	Y	N
Difficulty Swallowing	Y	N
Hoarseness	Y	N

Cardiovascular		
Chest Pain	Y	N
Palpitations	Y	N
Fainting Spells	Y	N
Leg Swelling/Pain	Y	N
Arm Swelling/Pain	Y	N

Respiratory		
Cough	Y	N
Wheezing	Y	N
Shortness of Breath	Y	N
Coughing Blood	Y	N
Pain with Breathing	Y	N

Breast		
Mass	Y	N
Pain	Y	N
Nipple Discharge	Y	N
Change in Size	Y	N
Change in Shape	Y	N

Gastrointestinal		
Nausea	Y	N
Vomiting	Y	N
Jaundice	Y	N
Abdominal Pain	Y	N
Maroon/Black Stool	Y	N
Constipation	Y	N
Diarrhea	Y	N
Vomiting Blood	Y	N
Difficulty Swallowing	Y	N

Urinary		
Painful Urination	Y	N
Blood in Urine	Y	N
Increased Frequency	Y	N
Loss of Control	Y	N
Impotence	Y	N

Gynecological		
Vaginal Discharge	Y	N
Pelvic Pain	Y	N
Abnormal Bleeding	Y	N

Musculoskeletal		
Muscle Pain	Y	N
Spine Tenderness	Y	N
Swollen Joints	Y	N
Joint Redness	Y	N
Bone Pain	Y	N

Skin		
Rash	Y	N
Nodules	Y	N
Itchiness	Y	N
Lesions	Y	N

Neurological		
Confusion	Y	N
Seizures	Y	N
Fainting Spells	Y	N
Tremors	Y	N
Speech Change	Y	N
Headache	Y	N
Abnormal Gait	Y	N
Weakness	Y	N
Sensory Change	Y	N

Psychiatric		
Anxiety	Y	N
Depression	Y	N

Endocrine		
Excessive Urine	Y	N
Excessive Thirst	Y	N
Hot Flashes	Y	N
Heat/Cold Intolerance	Y	N

Hematological		
Nose Bleeds	Y	N
Bleeding Gums	Y	N
Easy Bruising	Y	N

Lymphatic		
Enlarged Lymph Nodes	Y	N
Swelling in Arms/Legs	Y	N

REFERRING PHYSICIANS: **Please list all referring physicians and others you are currently seeing.**

Physician	Address	Phone Number

PHARMACY: **Please list your pharmacy information.**

Pharmacy	Address	Phone Number

ADDITIONAL NOTES: **Please use this space to complete any additional notes that were not completed above.**

Patient Signature: _____

Patient Printed Name: _____

Date: _____