Marin Cancer Care

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HEALTH HISTORY INFORMATION
HEMATOLOGY

Information in this confidential record will not be released unless you have authorized us to do so.
Your history is very important to us. Please take the time to complete this accurately and fully.

Name _____ Preferred Name _____

Birthdate _____ Age _____

Address _____

City/State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Preferred Method of Contact: _____

Gender _____ Race _____ Ethnicity _____ Spoken Language _____

Employer _____ Occupation _____

Emergency Contact:

Name _____ Address _____

Relationship _____ Phone _____ Email _____

Name _____ Address _____

Relationship _____ Phone _____ Email _____

Referring Physician _____

Send copies to other physicians _____

_____

Medicare #: _____ Medi-Cal #: _____

INSURANCE **(primary)** _____ Plan _____

INSURANCE **(secondary)**_____ Plan _____

I hereby authorize Marin Cancer Care, A Medical Group, Inc., to release to my insurance Company, or its representative, any information regarding medical care rendered to me. I understand that I am financially responsible for the medical care rendered to me by Marin Cancer Care, A Medical Group, Inc.

Authorization for Release of Information, Medical Records, X-rays, etc., FROM:

_____

Patient's Signature _____Date_____

NAME _____

I. HEMATOLOGY HISTORY

When were you first told you had a blood disorder? _____

Do you have any of the following:

1. Bleeding Gums	☐ No	☐ Yes
2. Easy Bruising	☐ No	☐ Yes
3. Frequent nose bleeds	☐ No	☐ Yes
4. Frequent infections	☐ No	☐ Yes
5. Bleeding complications from surgery	☐ No	☐ Yes
6. Swollen lymph glands	☐ No	☐ Yes
7. History of blood clots	☐ No	☐ Yes

II. BLOOD TRANSFUSIONS AND DONATIONS

Have you ever had a blood transfusion? ☐ No ☐ Yes

If yes, when and why? _____

Any reaction? _____

Have you every donated blood? ☐ No ☐ Yes, *year* _____

III. ALLERGIES

Are you allergic to any medicine? ☐ No ☐ Yes

If yes, please list name	*your reaction:* (e.g., rash, shortness of breath)
_____	_____
_____	_____
_____	_____
_____	_____

Have you any other allergies? ☐ No ☐ Yes

If yes, please provide details _____

Pacemaker? ☐ No ☐ Yes If yes, please attach copy of device ID card

NAME _____

IV. MEDICATIONS

Please list all medications, including supplements and/or herbs - prescription and non-prescription

MEDICATIONS/SUPPLEMENTS/ VITAMINS	DOSE	HOW OFTEN	DURATION

Your Pharmacy **Phone Number ( )**

V. PAST MEDICAL HISTORY

Please check any of the following you have had and indicate the date of onset next to the item:

- ☐ Anemia
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Blood Clots
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis
- ☐ COPD/Emphysema
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Elevated Cholesterol
- ☐ Gallbladder Disease
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes Zoster(shingles)
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Liver Disease
- ☐ Pneumonia
- ☐ Prostate Trouble
- ☐ Psychiatric Diagnosis
- ☐ Sleep Apnea
- ☐ Abnormal TB Skin Test
- ☐ Thyroid Disease
- ☐ Ulcer Disease
- ☐ *Other*

_____

_____

_____

NAME _____

HOSPITALIZATIONS

Have you ever been hospitalized? ☐ No ☐ Yes
If yes, please indicate reason for hospitalization *Date*

_____ _____

_____ _____

Please tell us when you last had a:

1) Stool test for blood: Date: _____
2) Sigmoidoscopy or colonoscopy: (circle which) Date: _____
3) Pneumonia shot Date: _____
4) Shingles shot Date: _____

Women:

1) Pap Smear: Date: _____
2) Mammogram: Date: _____

Men:

1) Prostatic Specific Antigen (PSA): Date: _____

WOMEN

Age at first Period? _____ Age at Menopause? _____
Menses: ☐ Irregular ☐ Heavy ☐ Painful ☐ Abnormal Bleeding ☐ Discharge
Date of last Menses _____
Date of last Pap Smear _____ *Result*: ☐ Normal ☐ Abnormal

Number of: Pregnancies _____ Deliveries ____ Therapeutic Abortions ____ Miscarriages ____
Complications _____
Age at first term pregnancy?_____ Did you breast feed? ☐ No ☐ Yes Total Length? _____
Birth Control Pills? ☐ No ☐ Yes
*If yes, for how long?*_____ W*hen did you last take them?*_____

Breast: ☐ Lump ☐ Discharge ☐ Pain ☐ Swelling

Have you ever taken hormone replacement? ☐ No ☐ Yes
*If yes, what?*_____ *For how long?* _____

Have you ever taken fertility drugs? ☐ No ☐ Yes
If yes, what? _____ *For how long?* _____

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has any medical or surgical treatment ever been recommended and not performed? ☐ No ☐ Yes
If yes, what? _____

Toxic Exposure? ☐ No ☐ Yes
If yes, what? _____

NAME _____

VI. RADIATION THERAPY

Have you ever had radiation therapy? ☐ No ☐ Yes

VII. SURGERIES

Have you ever had surgery? ☐ No ☐ Yes

If yes, please indicate type of operation *Date*

_____ _____

_____ _____

_____ _____

VIII. HABITS

Do you drink alcoholic beverages? ☐ No ☐ Yes If no, have you in the past? _____

How many drinks per day _____ or drinks per week _____

Have you ever smoked cigarettes? ☐No ☐Yes

How many packs per day? _____ For how many years? _____

How old were you when you started? _____

Are you currently smoking? ☐ No ☐ Yes

If you quit, when did you quit? _____

Have you ever chewed tobacco? ☐ No ☐ Yes

Do you use medical marijuana? ☐ No ☐ Yes

Have you used recreational drugs? ☐ No ☐ Yes

Do you exercise? ☐ No ☐ Yes

If yes, what type and how often? _____

_____

What do you enjoy doing? _____

_____

NAME _____

IX. FAMILY HISTORY

		IF LIVING		IF DECEASED	
	Name	**Age**	**Health**	**Age**	**Cause**
Mother					
Father					
Sister Brother					
Sister Brother					
Sister Brother					
Sister Brother					
Sister Brother					
Spouse/Companion					
Son Daughter					
Son Daughter					
Son Daughter					
Son Daughter					
Son Daughter					

Do you have any 1st degree relatives with a blood disorder?_____

_____

_____

X. SOCIAL HISTORY

Where were you born? _____ Marital Status ☐ M ☐ D ☐ W ☐ Never Married

How many people live in your home now? ____

Who besides yourself? _____

Highest Grade Completed _____

Current Occupation _____

Previous Occupation _____

NAME _____

XI. REVIEW OF SYSTEMS

Please check if you have recently had any problems with:

HEAD □ None

- ☐ Trauma
- ☐ Headache

EYES □ None

- ☐ Glasses
- ☐ Contacts
- ☐ Pain
- ☐ Dry Eyes
- ☐ Tearing
- ☐ Shimmering Spots
- ☐ Color Blindness
- ☐ Vision: Blurred/Double
- ☐ Blind Spots, Blindness

EARS □ None

- ☐ Pain
- ☐ Ringing
- ☐ Discharge
- ☐ Infections
- ☐ Hearing Problems
- ☐ Hearing Aid

MOUTH □ None

- ☐ Pain
- ☐ Dentures
- ☐ Partial Plates
- ☐ Ulcers/cold sores
- ☐ Dry Mouth
- ☐ Tongue: Sore, Enlarged
- ☐ Change in Taste
- ☐ Periodontal Disease
- ☐ Teeth Problem

NOSE & THROAT □ None

- ☐ Hoarseness
- ☐ Nose Bleeds
- ☐ Change in Smell/Voice
- ☐ Nasal Obstruction
- ☐ Sinus Problems

RESPIRATORY □ None

- ☐ Chest Pain
- ☐ Chills
- ☐ Positive TB Skin Test
- ☐ Cough Sputum; Color: _____
- ☐ Fever
- ☐ Shortness of Breath
- ☐ Night Sweats
- ☐ Coughing Blood
- ☐ Wheezing
- ☐ Abnormal Chest X-ray

CARDIOVASCULAR □ None

- ☐ Angina
- ☐ Abnormal Cardiogram (EKG)
- ☐ Shortness of Breath
- ☐ Rapid Heart Beat
- ☐ Irregular Heart Beat (Palpitations)
- ☐ Pain: Jaw, Neck, Chest, Mid-Back
- ☐ Leg Cramps
- ☐ Varicose Veins or Phlebitis
- ☐ Swollen Feet or Ankles

GASTROINTESTINAL □ None

- ☐ Poor Appetite
- ☐ Nausea
- ☐ Diarrhea
- ☐ Rectal Bleeding
- ☐ Jaundice
- ☐ Heartburn
- ☐ Trouble Swallowing
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Laxative Use
- ☐ Bloating
- ☐ Constipation
- ☐ Trouble Chewing
- ☐ Gallbladder Problems
- ☐ Food Intolerance or Allergy
- ☐ Vomiting Blood
- ☐ Belching
- ☐ Change in Stool Size
- ☐ Black, White, Bloody Stool
- ☐ Hemorrhoids

NAME _____

MUSCULOSKELETAL ☐ None

☐ Bone Pain ☐ Muscle Pain ☐ Back Pain

☐ Joint: Stiffness, Swelling, Pain or Redness; which one(s): _____

SKIN ☐ None

☐ Rash ☐ Dryness ☐ Sore which does not heal

☐ Itch ☐ Burning ☐ Biopsy or Removal of Lesion

☐ Change in: Birthmarks, Hair, Nails, moles

HEMATOLOGICAL ☐ None

☐ Easy Bruising or Bleeding ☐ Swollen Lymph Nodes: Neck, Groin, Under Arms

NEUROLOGICAL & PSYCHOLOGICAL ☐ None

☐ Fainting ☐ Dizziness ☐ Loneliness

☐ Tingling ☐ Numbness ☐ Depression

☐ Personality Change ☐ Nervousness ☐ Worry

☐ Incoordination ☐ Paralysis ☐ Weakness

☐ Unconsciousness ☐ Irritability ☐ Thick Speech

☐ Suicidal Thoughts ☐ Seizures ☐ Convulsions

☐ Daydreaming ☐ Loss of Temper ☐ Fatigue

☐ Difficulty Walking in the Dark

ENDOCRINE & METABOLISM ☐ None

☐ Poor Energy ☐ Increased Thirst ☐ Appetite Change

Feel : ☐ Too hot / ☐ Too Cold

Recent Weight Change : ☐ None ☐ Loss /☐Gain of_____ pounds since _____

Present Weight: _____lbs. Usual Weight _____lbs. Greatest Weight _____lbs.

GENITOURINARY ☐ None

☐ Pain with Urination or Intercourse

☐ Urinate Frequently During the Day: _____ times

☐ Urinate Frequently During the Night: _____ times

☐ Urine Stream: Weaker, Smaller, Dribbling, Difficulty Starting or Stopping

☐ Incontinence

☐ Dark or Red Urine

SEXUALITY

Are you sexually active? ☐ No ☐ Yes

Are you having any problems with sexuality as a result of cancer or its treatments?

_____

Patient Health History dictated by: _____Date: _____