(Office Use Only)
Patient Name: _____ **MR#** _____

HEMATOLOGY/ONCOLOGY: NEW PATIENT FORM

Date: _____/_____/_____ Age: _____
Patient Name: _____ Date of Birth: _____/_____/_____
Social Security #: _____-_____-_____ Birth Place: _____
Home Phone: (_____)_____-_____ Cell/Wk. Phone: (_____)_____-_____
Address: _____
City : _____ State: _____ Zip: _____
Email: _____
Referring Physician: _____ Primary Care Provider: _____
Accompanied By: _____ ☐ Permission to discuss care in front of the above person.

REASON FOR TODAY'S VISIT: _____

Date when the symptoms began (approximate):

SYSTEM REVIEW: Do you currently suffer from any of the following? Place an 'X' in the No or Yes columns:

No	Yes	Constitutional	No	Yes	Cardiovascular	No	Yes	Neurological	No	Yes	Musculoskeletal
		Chills			Chest pain			Dizziness			Back pain
		Fatigue			Leg swelling			Extremity numbness			Joint Pain
		Fever			Palpitations			Extremity weakness			Joint swelling
		Weight gain			Passing out			Gait disturbance			Leg pain
		Weight loss						Headache			Muscle weakness
		Lethargy						Seizures			Neck pain
								Hallucinations			Limited motion
No	**Yes**	**HEENT**	**No**	**Yes**	**Gastrointestinal**	**No**	**Yes**	**Integumentary**	**No**	**Yes**	**Hematologic**
		Blurred vision			Abdominal pain			Breast discharge			Easy bleeding
		Double vision			Blood in Stool			Breast lump			Easy bruising
		Difficulty swallowing			Diarrhea			Hives			Swollen lymph nodes
		Loss of vision			Heartburn			Rash			Anemia
		Nosebleeds			Loss of appetite			Skin lesions/sores			Clotting issues
		Sore throat			Nausea			Unusual masses			
		Ringing in the ears			Vomiting			Breast pain	**No**	**Yes**	**----Women Only------**
		Mouth sores			Constipation			Nipple inversion			Irregular menses
								Itching			Vaginal bleeding
No	**Yes**	**Respiratory**	**No**	**Yes**	**Genitourinary**	**No**	**Yes**	**Psychiatric**	**No**	**Yes**	**------Men Only--------**
		Chronic Cough			Pain with urination			Anxiety			Erectile dysfunction
		Cough			Blood in urine			Depression			Problems with libido
		Coughing up blood			Frequent urination			Suicidal thoughts			Penile discharge
		Shortness of breath						Hallucinations			
		Wheezing				**No**	**Yes**	**Immunological**			
								Unusual allergic reactions			

(Office Use Only)
Patient Name: _____ **MR#** _____

HEMATOLOGY/ONCOLOGY: NEW PATIENT FORM

MEDICAL HISTORY: *Place a Check in the box next to the following conditions you have been diagnosed with:*

☐ Adrenal Disease	☐ Congestive Heart Failure	☐ Hyperlipidemia	☐ Parathyroid Disease
☐ Allergies	☐ COPD	☐ Hypertension	☐ Pituitary Disease
☐ Anemia	☐ Depression	☐ Hyperthyroidism	☐ Prostatic Hypertrophy (Benign)
☐ Angina	☐ Diabetes Type I	☐ Irritable Bowel	☐ Renal Disease
☐ Arthritis	☐ Diabetes Type 2	☐ Kidney Stones	☐ Seizure Disorder
☐ Anxiety	☐ Diabetes Gestational	☐ Migraines	☐ Stroke
☐ Asthma	☐ Gallbladder Disease	☐ Obesity	☐ Systemic Lupus
☐ Atrial Fibrillation	☐ GERD	☐ Osteoporosis	☐ Thyroid Disorder
☐ Blood Clots	☐ Headaches		☐ Tuberculosis (TB)
☐ Cholesterol	☐ Heart Disease		☐ Ulcer of Stomach or Bowel

☐ Hepatitis/Liver Disease: ☐A ☐B ☐C ☐D ☐E ☐F ☐GBV-C ☐Autoimmune ☐Drug Induced ☐:_____

☐ Cancer: ☐ Bladder ☐ Breast ☐ Colon ☐ Gastric ☐ Lung ☐ Thyroid ☐ Neck ☐ Ovarian ☐:_____

☐ Renal (Kidney) Disease: ☐ On Dialysis ☐Stage 1-2 ☐Stage 3-4 ☐Stage 5(end) ☐:_____

☐ Other: _____

Immunizations: Date of last Flu Shot:_____ Date of last Pneumonia Shot:_____

DIAGNOSTIC HISTORY: *Place a Check in the box next to the testing that apply:*

	Body Part	*Date*	*Facility*
☐ Last MRI			
☐ Last CT			
☐ Fine Needle Aspiration			
☐ X-Rays			
☐ Ultra Sound			
☐ Pathology			
☐ Other Testing			

SURGICAL HISTORY: *Place a Check in the box next to the following surgeries you have had:*

	Specify Type & Surgeon	***Date***		***Specify Type & Surgeon***	***Date***
☐ Angioplasty			☐ Cystectomy		
☐ Appendectomy			☐ Hysterectomy		
☐ Back surgery			☐ Dialysis		
☐ Blood transfusion			☐ Mastectomy		
☐ Bone marrow biopsy			☐ Gastric volvulus		
☐ Bone marrow transplant			☐ Small Bowel Resection		
☐ Brachytherapy			☐ Thyroidectomy		
☐ Breast biopsy			☐ Hemicolectomy		
☐ CABG			☐ Hysterectomy		
☐ Cholecystectomy			☐Other:_____		
☐ Chemotherapy			☐ Other:_____		
☐ Colostomy			☐Other:_____		
☐ Craniotomy			☐Other:_____		

(Office Use Only)
Patient Name: _____ **MR#** _____

The South Bend Clinic
A Lifetime of Care

HEMATOLOGY/ONCOLOGY: NEW PATIENT FORM

FAMILY HISTORY: *Circle the letter that represents the family member(s):* Mother (**M**), Father (**F**), Sister (**S**), Brother (**B**)
Paternal: Grandmother (**PGM**), Grandfather (**PGF**), Aunt (**PA**), Uncle (**PU**)
Maternal: Grandmother (**MGM**), Grandfather (**MGF**), Aunt (**MA**), Uncle (**MU**)

Father: ☐ Alive & Well ☐ Deceased, Cause of Death:_____ Age: _____

Mother: ☐ Alive & Well ☐ Deceased, Cause of Death:_____ Age: _____

Anemia	M F S B PGM PGF PA PU MGM MGF MA MU	Cancer Bladder:	M F S B PGM PGF PA PU MGM MGF MA MU
Blood disorder	M F S B PGM PGF PA PU MGM MGF MA MU	Cancer Breast:	M F S B PGM PGF PA PU MGM MGF MA MU
Clotting disorder	M F S B PGM PGF PA PU MGM MGF MA MU	Cancer Colon:	M F S B PGM PGF PA PU MGM MGF MA MU
COPD	M F S B PGM PGF PA PU MGM MGF MA MU	Cancer Gastric:	M F S B PGM PGF PA PU MGM MGF MA MU
Coronary artery disease	M F S B PGM PGF PA PU MGM MGF MA MU	Cancer Lung:	M F S B PGM PGF PA PU MGM MGF MA MU
Depression	M F S B PGM PGF PA PU MGM MGF MA MU	Cancer Thyroid:	M F S B PGM PGF PA PU MGM MGF MA MU
Diabetes	M F S B PGM PGF PA PU MGM MGF MA MU	Cancer Neck:	M F S B PGM PGF PA PU MGM MGF MA MU
Hypertension	M F S B PGM PGF PA PU MGM MGF MA MU	Cancer Ovarian:	M F S B PGM PGF PA PU MGM MGF MA MU
Osteoporosis	M F S B PGM PGF PA PU MGM MGF MA MU	Cancer (type):_____	M F S B PGM PGF PA PU MGM MGF MA MU
Stroke	M F S B PGM PGF PA PU MGM MGF MA MU	Cancer (type):_____	M F S B PGM PGF PA PU MGM MGF MA MU
Thyroid disorder	M F S B PGM PGF PA PU MGM MGF MA MU	Cancer (type):_____	M F S B PGM PGF PA PU MGM MGF MA MU
Other:_____	M F S B PGM PGF PA PU MGM MGF MA MU	Cancer (type):_____	M F S B PGM PGF PA PU MGM MGF MA MU

SOCIAL HISTORY:

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children: ☐ Boy(s) #_____ ☐ Girl(s) #_____

Siblings: ☐ Sister(s) #_____ ☐ Brother(s) #_____

Other Family: How many siblings does your mother have? ☐ Sister(s) #_____ ☐ Brother(s) #_____

How many siblings does your father have? ☐ Sister(s) #_____ ☐ Brother(s) #_____

Work: Occupation _____ ☐ Part-time ☐ Full-time ☐ Retired ☐ Disabled

Tobacco: Do you use tobacco? ☐ No/Never ☐ Yes ☐ Former - How long ago? _____ Age Quit:_____

Type/Status: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew ☐ Snuff ☐ Vape ☐ Other:_____
How may packs per day? ____ How many years?____

(Office Use Only)
Patient Name: _____ **MR#** _____

HEMATOLOGY/ONCOLOGY: NEW PATIENT FORM

Caffeine:	Do you drink caffeinated beverages ☐ No ☐ Yes, what type: _____ Cups per day: _____
Alcohol:	Do you drink alcohol? ☐ No ☐ Yes, what type: _____ Amount: _____
	Frequency: ☐ daily ☐ weekly ☐ monthly ☐ socially ☐ occasionally ☐ rarely
Drugs:	Do you now, or have you in the past used illegal or illicit drugs? ☐ No ☐ Yes
	Do you have concerns about sexual function or fertility? ☐ No ☐ Yes
Advance Directives:	Have you prepared a **LIVING WILL** or **ADVANCED DIRECTIVES**? ☐ No ☐ Yes
	If so, is it on file with the SB Clinic or local hospital? ☐ No ☐ Yes
	Do you have a medial power of attorney? ☐ No ☐ Yes, whom?_____

Allergies to Medications : *List any allergies or intolerances to medications & include your reaction*

Medication Allergy	Reaction(s)

Are you allergic to IODINE? ☐ No ☐ Yes, what happens?_____

Medications: *List all current medications you are taking*

Medication	Dose (strength & quantity)	Prescribing Doctor
1.		
2.		
3.		
4.		
5.		
6		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Continue on back page if needed….

Form filled out by:_____