

PETER SHENG, M.D. Inc.

PATIENT HISTORY FORM

Hematology/Oncology

PATIENT NAME : _____

FAMILY DOCTOR _____ PHONE NUMBER _____

PHARMACY NAME _____ PHONE NUMBER _____

CHIEF COMPLAINT _____

ALLERGIES __ YES __ NO If YES, list names and type of reaction

PROBLEM LIST : Please check 'Y' if there is problem, 'N' if no problem.

		N	Y			N	Y			N	Y
Personal Health	High Blood Pressure			Neuro-logic	Fainting/Blackout			Ear Throat Mose Mouth	Hearing Changes		
	Chicken Pox				Dizziness				Sinus Problem		
	Cancer				Headache				Earache		
	Bleeding Problems				Numbness/Tingling				Sore Throat		
	HIV Positive				Seizure				Sore Mouth		
	Diabetes				Convulsions				Dry Mouth		
	Kidney Problems				Balance Problem				Other		
	Hepatitis				Paralysis						
	Other				Other						
Cardiovascular	Circulation Problem			Thyroid	Goiter			Skin	Hir Loss		
	Heart Problem				Overactive				Open Wound		
	Chest Pain				Underactive				Swelling		
	Other				Other				Other		
Respi-ratory	Short of Breath			Muscu-skeletal	Joint Pain			Urination	Frequent Urination		
	Sputum/Color				Limitation of Motion				Pain with Urination		
	Coughing up blood				Muscle Weakness				Blood in Urine		
	Cough				Other				Burning Urinating		
	Other								Other		
Breast	Fibrocystic Condition			Psychia- tric	Emotion			Genital	Male/Female Problem		
	Breast Lump				Sleep				Hysrectomy		
	Other				Other				Other		
GI	Stomach Problem			Other	Vomiting				Blood in Stool		
	Chewing/Swallow Problem				Taste/Smell Change				Jaundice		
	Diarrhea				Use Laxative				Illeoconduit		
	Bowel Problem				Colostory				Appetite Problems		
	Nausea				Ileostomy				Hemorrhoid		
	Constipation										
Eye	Visual Disturbance			Other							
Pain				Site							

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Previous Hospitalizations/Chemotherapy/Radiation Therapy (PLEASE LIST, 'NONE' if never had)

- 1. _____ Date _____
- 2. _____ Date _____
- 3. _____ Date _____

Previous Operations (PLEASE LIST, 'NONE' if never had)

- 1. _____ Date _____
- 2. _____ Date _____
- 3. _____ Date _____

Family Health History : Check all that apply

Health Status or Cause of Death of Parents _____
 Health Status or Cause of Death of Siblings _____
 Health Status or Cause of Death of Children _____
 Hereditary Family Disease Stroke Lung Disease Heart Disease High Blood Pressure
 Diabetes Cancer Site _____
 Specific Diseases Related to Chief Complaints _____

Social History :

Married Divorced Widowed Single
 Living Arrangements _____
 Do you have any difficulty caring for yourself? Yes No
 If YES, do you use : Cane Walker Brace Wheelchair
 Other _____
 Do you have Pacemaker Artificial Limbs Implantable Devices, i.e. Mediport
 Other _____
 How many hours do you sleep at night : _____
 Do you currently use services of home health agency? Yes No List agent if yes _____
 Current Employment _____ Employer _____
 Occupational History _____
 Other Relevant Social Factors _____

For Woman Only :

Are you pregnant ? Yes No
 Number of Pregnancies _____ Number of Births _____
 Your last gynecological Exam Date _____
 Your last PAP smear Date _____ Result _____
 Last Menstrual Period, when _____

Use of Tobacco Products Yes No

Length of time used _____
 Quantity used _____

Use of Alcohol Products Yes No

Frequency of use _____

Use of Recreation Drugs Yes No

List _____ Length of Time Used _____
 Frequency/Quantity Used _____

 Patient Signature

 Date