HOAA

HEMATOLOGY & ONCOLOGY
ASSOCIATES OF ALABAMA, LLC

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Cell phone: _____ Email: _____

Occupation / Employer: _____ Retired: _____ Disabled: _____

Did you serve in the military? YES: _____ NO: _____ Branch: _____

Allergies:

Medication	Describe reaction

Medications, Vitamins, and Supplements taking at home:

Medication	Dosage	How often	**Medication**	Dosage	How often

Current Healthcare Providers:

Primary Care Provider: _____ Phone: _____

Provider: _____Phone: _____Specialty: _____

Provider: _____Phone: _____Specialty: _____

Provider: _____Phone: _____Specialty: _____

Pharmacy Information

Pharmacy: _____ Phone: _____

Address: _____

Patient Name: _____ DOB: _____

Please check any of the diseases listed below that you have been diagnosed with:

Hypothyroidism		High Cholesterol		Diabetes		Anxiety	
High Blood Pressure		Peripheral Vascular Disease		Congestive Heart Failure		Ulcerative Colitis	
Blood Clot		Pulmonary Embolism		Osteoporosis		Stroke	
Rheumatoid Arthritis		Osteoarthritis		Chronic Sinusitis		Cancer	
Polymyalgia Rheumatica		Lumbar Disk Disease		Kidney Stones		Heart Attack	
COPD		Asthma		Hepatitis		Radiation Therapy	
Stomach Ulcers		GI bleed		TIA		Anemia	
Crohn's Disease		Migraines		Depression		Iron Deficiency	
Cirrhosis		Gallstones		Dialysis		Miscarriages	
Carpal Tunnel Syndrome		Irritable Bowel Syndrome		Coronary Artery Disease		Gastroesophageal Reflux disease	
Peripheral Neuropathy		Seizure Disorder		Atrial Fibrillation			
Frequent Urinary Infections		Kidney Disease		Fibromyalgia			

Past Surgical History:

Please check all that apply:

Tonsillectomy		Carpal Tunnel Release		Other (Please Specify)	
Adenoidectomy		Vasectomy			
Cataract Surgery		Hernia repair			
Sinus Drainage		Mastectomy			
Thyroidectomy		Prostate surgery			
Cervical Disk Fusion		Hemorrhoidectomy			
CABG		Meniscus Repair			
Coronary Artery Stenting		Varicose Vein Stripping			
Pacemaker insertion		Rotator Cuff repair			
Aneurysm repair		Knee replacement			
Exploratory Laparoscopy		Hip replacement			
Appendix removal		C-section			
Gall bladder removal		Skin cancer removal			
Spleen removal		Femoro-popliteal Bypass Graft			
Gastric bypass/sleeve		Breast Surgery			
Hysterectomy with ovary removal		Tubal Ligation			
Hysterectomy without ovary removal					

Patient Name: _____ DOB: _____

Social History:

Have you ever used tobacco? (Select): Yes / No Packs per day?_____ How many years?_____

Have you quit? (Select): Yes / No If so, when? _____

Have you ever used alcohol? (Select): Yes / No How much & how often? _____

What is your current/prior job(s) / position? _____

Have you ever had contact with chemicals or other toxins such as asbestos? If so, please describe:

_____

Marital Status (Select Applicable): Never Partnered Married Separated Divorced Widowed

Biological children? How many?____Boys?___Girls?___Adopted/Step children? Boys?_____Girls?_____

Do you have any of the following?

Advanced Directive (Select): Yes / No

Living will (Select): Yes / No

DNR (Select): Yes / No

Would you accept blood products? (Select): Yes / No

Family History:

Has any blood relative ever experienced any of the following conditions? Please describe including relationship:

Cancer:_____

Blood Disorder:_____

Immediate Family Member (Relationship Type)	Age of Onset	Recent Medical Conditions/Diseases (i.e. Cancer, Diabetes, Heart attack etc.)	Deceased	Age at Death	Cause of Death

Patient Name: _____ DOB: _____

Current Health Screenings:

Health Screening	Most recent date performed
Colonoscopy	
Mammogram	
Stress Test	
Pap Smear	
Flu Vaccine	
Pneumonia Vaccine	
Other (Please Specify)	

Review of Symptoms (please mark "yes" or "no". If yes, please describe)

Have you experienced any of these symptoms recently?

Symptoms	Yes	No	Description
Weight loss			
Fever			
Fatigue			
Night sweats			
Headaches			
Visual Changes			
Hearing Changes			
Recent Cough			
Shortness of Breath			
Coughing up blood			
Appetite Changes			
Nausea/Vomiting			
Back Pain			
Loss of Consciousness			
Change in Bowel Habits			
Urinary Problems			
Kidney Stones			
Heavy Menstrual Cycles			
Ice Cravings			
Leg Cramps			
Dark or Bloody Stools			
Excess Bleeding/Bruising			