

Hematology & Oncology Associates of Rhode Island
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PATIENT INFORMATION FORM

Name _____	Age _____	DOB _____
Primary Physician _____	Referred by _____	
REASON FOR VISIT: _____		

MEDICAL PROBLEMS: Please check all that apply

- | | | | |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Tuberculosis | | | |
| <input type="checkbox"/> Other _____ | | | |
| <input type="checkbox"/> Surgeries _____ | | | |
| <input type="checkbox"/> Allergies _____ | | | |
| <input type="checkbox"/> Blood Transfusion: _____ | | | |

SOCIAL:

- | | NO | YES | |
|-----------|--------------------------|--------------------------|-------------------|
| • Smoking | <input type="checkbox"/> | <input type="checkbox"/> | _____ Packs/Day |
| • Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | _____ Drinks/Week |

Occupation: _____

Marital Status: S M D W

FAMILY HISTORY:

- High Blood Pressure
- Heart Disease
- Diabetes
- Stroke
- High Cholesterol
- Thyroid Disease
- Osteoporosis
- Blood Disorder, Type _____
- Cancer, Type _____

REVIEW OF SYSTEMS: Have any of the symptoms listed below have recently been a significant problem to you? Please Circle either **YES** or **NO**

- | | | | | | |
|---------------------|---|---|-------------------------|---|---|
| • Weight Loss | Y | N | • Chest Pain | Y | N |
| • Night Sweats | Y | N | • Varicose Vein | Y | N |
| • Fever | Y | N | • Sleep Patterns Normal | Y | N |
| • Chills | Y | N | • Skin Rash | Y | N |
| • Headache | Y | N | • Itch | Y | N |
| • Blurred Vision | Y | N | • Joint Pain | Y | N |
| • Double Vision | Y | N | • Neck Pain | Y | N |
| • Hay Fever | Y | N | • Back Pain | Y | N |
| • Drug Allergies | Y | N | • Other Pain | Y | N |
| • Tremors | Y | N | • Ear Infection | Y | N |
| • Dizzy Spells | Y | N | • Sore Throat | Y | N |
| • Numbness/Tingling | Y | N | • Sinus Problems | Y | N |
| • Excessive Thirst | Y | N | • Urine Problems | Y | N |
| • Too hot/cold | Y | N | • Painful Urination | Y | N |
| • Tired/Sluggish | Y | N | • Bowel Problems | Y | N |
| • Abdominal Pain | Y | N | • Constipation | Y | N |
| • Nausea | Y | N | • Wheezing | Y | N |
| • Vomiting | Y | N | • Frequent Cough | Y | N |
| • Indigestion | Y | N | • Shortness of Breath | Y | N |
| • Heartburn | Y | N | • Swollen Glands | Y | N |
| • Appetite, Normal | Y | N | | | |

FOR WOMEN:

Pregnancies # _____ Children _____

Other _____

Age at first menses _____

Date of last menses _____ N/A

Birth Control Pills N Y How long _____

Hormone Replacement N Y How long _____

Therapy _____ Date off Therapy _____