Abington Hematology Oncology Associates, Inc. (Please complete **all** information)

First Name: _____**M.I.** _____ **Last:** _____
Address: _____ **Marital Status:** Married Single Other
_____ **Sex:** (circle one) Male Female

City: _____**State:** _____ **Employer Name**: _____

Zip Code: _____ **Emp. Status**: □ Employed □ Unemployed □ Retired

Home Phone: **(** **)** _____-_____ **Empr. Phone #: (** **)** _____-_____

Cell Phone: **(** **)** _____-_____

Contact Preference: □ Home phone □Cell □mail or □ Email _____

Date of Birth: _____/_____/_____ **Preferred Language:**_____

Soc. Sec. #: _____ **Race:**_____

Ethnicity: □ Non Hispanic or Latino □ Hispanic or Latino

***Primary Insurance Carrier*: □** None ***Secondary Insurance Carrier*: □** None

Prim. Ins. Name: _____ **Sec. Ins. Name**: _____

Prim. Policy Effective Date: _____ **Sec. Policy Effective Date**: _____

Claims Address: _____ **Claims Address:**_____

City, State: _____,_____ **City, State:** _____,_____

Zip Code: _____ **Zip Code**: _____

Primary Ins. Phone: **(** **)** _____-_____ **Sec. Ins. Phone: (** **)** _____-_____

Prim. Insured ID #: _____ **Sec. Insured ID #:**_____

Prim. Group Policy #:_____ **Sec. Group Policy #:**_____

Prim. Group Name: _____ **Sec. Group Name**: _____

Subscriber: (Mark if Same as Patient □)

Insured Name:_____ **Home Phone: (** **)** _____-_____

Date of Birth: _____/_____/_____

Sex: Male Female (circle one) **Relationship to Patient:** Spouse Child Other

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Referring Physician:_____ **Phone #: (** **)** _____-_____

Referring Phys. Address:_____ **City, State**: _____,_____

Family/Primary Physician: _____ **Phone #: (** **)** _____-_____

Family/Primary Address:_____ **City, State**: _____,_____

Emergency Name #1:_____ **Relationship:** _____**Phone #:(** **)** _____-_____

Emergency Name #2:_____ **Relationship:** _____ **Phone #:(** **)** _____-_____

Patient Signature _____**Date:**_____

2510 Maryland Road, Suite 175, Willow Grove, PA 19090 Phone 215.706.2034

1648 Huntingdon Pike, Suite 1000, Meadowbrook, PA 19046 Phone 215.947.5460

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE _____/_____/_____ DATE OF LAST PHYSICAL EXAM _____/_____/_____

LAST NAME _____ FIRST NAME: _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH: ____/_____/_____

What is the main reason for your visit today? (Describe your problem in detail)

_____

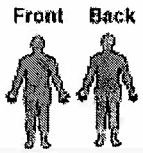
_____

_____

History of Present Illness

Please answer the following questions

Location of the problem
Abdomen Back Leg
Other _____



How long does the problem last?
30 minutes 1 hour It is always there
Other _____

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other _____

Is anything else occurring at the same time?
YES NO If yes, please explain.
Nausea Rash Headaches
Other _____

Is the problem constant or variable?
Dull then Sharp Very sharp then leaves Always there
Other _____

Does anything help or make the problem worse?
Moving around Standing up Lying on my side
Other _____

Does the problem interfere with your normal functions?
Yes ☐ No ☐ If yes, please explain
_____

Past Medical, Family & Social History

List all serious illnesses in your immediate family. (Example: diabetes. tuberculosis, breast cancer, heart disease, etc.,)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

List any personal past illness and/or surgeries and when they occurred.

Illness or Surgery	Date

Are you on a special diet? Yes No (If Yes, please explain)
_____
_____

Do you have allergies to any medications or contrast during x-rays?
Yes No (If Yes, please explain)
_____
_____

Do you smoke? ☐ Yes ☐ No
How much? _____How long?_____

Do you drink? ☐ Yes ☐ No
If yes, how much? _____

Do you exercise regularly? ☐ Yes ☐ No
If yes, how much? _____

Are you currently taking any medication? If Yes, please list all with doses and times.

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Last Menstrual period _____ Number of Pregnancies_____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Weight Loss	Y	N
Drenching sweats at night	Y	N

Other _____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other _____

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other _____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other _____

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Black or Tarry stools	Y	N
Bleeding	Y	N
Diarrhea/constipation	Y	N
Get Full easy	Y	N

Other _____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other _____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other _____

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other _____

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N

Other _____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Frequent Urination	Y	N
Nightime Urination	Y____x's	N

Other _____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other _____

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other _____

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other _____

Physician use only: (Comments/Notes)

Physician:_____ _____Date_____/_ _____/_____