Los Angeles Hematology/Oncology Medical Group
New Patient Registration and Medical Health History Questionnaire

NAME: _____ AGE: _____ DATE: _____

PHYSICIANS you are seeing today: _____

PHYSICIANS you have seen in the past: _____

_____

CURRENT MEDICAL PROBLEMS: _____

_____

_____

OTHER CONCERNS you would like to discuss with the physician: _____

_____

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):

_____

_____

_____

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take: _____

_____

_____

ALLERGIES: _____

_____

_____

_____

SENSITIVITIES: _____

_____

_____

_____

List SURGERIES you have had (include year, surgeon, hospital): _____

_____

_____

_____

Describe HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital): _____

_____

_____

_____

Have you had (circle):	migraines	hepatitis	mono	ulcer
bleeding problem	blood clots	head injury	drug addiction	gallstones
tuberculosis	STDs	seizures	memory trouble	arthritis
psoriasis	heart murmur	rheumatic fever	polio	shingles
alcoholism	depression	mental illness	gout	hemorrhoids
hearing trouble	vision trouble	history of cancer	blood clots	blood disorders
blood transfusions	other_____			

Please complete this form and fax to: (213) 482-8868 before your scheduled appointment.

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WOMEN

Age at first period _____ Date of last normal period _____ No. of pregnancies _____

No. of live births _____ No. of children living with you _____ Birth control method _____

Have you ever taken any hormonal therapies?_____ If yes what type?_____

Date of last Pap _____ Done where _____

Date of last mammogram _____ Done where _____

Do you have (circle):

irregular periods	bad menstrual cramps	heavy periods	pelvic pain	infertility
female trouble	hot flashes	vaginal dryness	vaginal discharge	vaginal odor
vaginal itching	PMS	breast problems	abnormal mammogram	abnormal Pap smear

ALL

Who in your *family* has/had (circle if cause of death and write age of death)

heart disease _____ genetic disorder _____

diabetes _____ cancer _____

thyroid disease _____ alcoholism _____

mental illness _____ arthritis _____

glaucoma _____ asthma _____

allergies _____ stomach problems _____

tuberculosis _____ high blood pressure _____

List any other diseases that run in your family and specify your relationship to each family member listed. _____

_____

When was your last:

tetanus shot _____	flu shot _____	EKG _____
TB test _____	HIV test _____	sigmoidoscopy _____
chest x-ray _____	pneumonia shot _____	hepatitis vaccine _____
rectal exam _____	blood test _____	colonoscopy_____

Have you previously had a PSA blood test?_____

Who lives in your household? _____

Where do/did you work? _____

Describe your education/upbringing, etc _____

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How much do you weigh? _____ How much would you like to weigh? _____ Heaviest weight _____

Do/did you EXERCISE? _____ How much? _____ hrs/wk No. of years? _____ Year you QUIT _____

Do/did you SMOKE? _____ How much? _____ packs/day No. of years _____ Year you QUIT _____

Do/did you DRINK alcohol? _____ How much? _____ drinks/week No. of years _____

Year you QUIT _____ Previous or current problem with alcohol? _____ AA? _____

Do/did you use (circle): caffeine Nutrasweet marijuana cocaine chewing tobacco diet pills

Do you wear seat belts? _____ Ride a motorcycle/bicycle? _____ Do you wear sunscreen? _____

Describe your diet. _____

_____

Describe your skin problems. _____

_____

Describe lung and breathing problems. _____

_____

Describe problems with your stomach, intestines, colon, digestion, or bowel movements. _____

_____

Describe any urinary trouble. _____

_____

Describe sexual concerns. _____

_____

Describe any bone, muscle, or joint problems. _____

_____

Describe any hormone problem. _____

_____

Describe any problems with your thinking, concentration, moods, energy level, interest in life, etc. _____

_____

Describe problems with strength, sensation, coordination, or neurologic function. _____

_____

Anything else? _____

_____

_____

_____

Please sign and date: _____