AVAM
CANCER AND BLOOD SPECIALISTS, LLC

NEW PATIENT FORM

NEW PATIENT & FAMILY HISTORY

Today's Date: ____________

Last Name: ____________________________ First Name:______________________ M.I.: ____________________

Date of Birth: _____________________ Marital Status: _____________________ Race: _______________________

Home Phone: _____________________ Mobile Phone: ____________________ Work Phone: __________________

Patient Address: ___________________________________ City:________________ State: ___________________

Zip Code: _____________ Email: __________________ Ethnicity (check or leave blank) Hispanic/Latino or Non-Hispanic/Latino

Preferred Language (optional): _____________________ Height: ______________ Weight: ___________________

Emergency Contract Name: _____________________________ Relationship: _______________________________

Emergency/Phone: ____________________________________ Emergency/Alternate Phone: __________________

Referring Doctor (If not known, list primary care physician)

Referring Doctor First Name: _________________________ Referring Doctor Last Name: ______________________

Practice Name: _____________________________________ Phone Number: ______________________________

Practice Address: ____________________________________ City:________________ State: __________________

Zip Code: _________________ Email: _______________________________

Reason for physician referral (please provide details with dates)

MEDICAL CONDITIONS

PSYCHOLOGICAL

Condition	Response
ADD/ADHD:	☐ Yes ☐ No
Anxiety/Depression:	☐ Yes ☐ No
Bipolar Disorder:	☐ Yes ☐ No
Dementia:	☐ Yes ☐ No
Eating Disorder:	☐ Yes ☐ No
OCD:	☐ Yes ☐ No
Post-Traumatic Stress Syndrome:	☐ Yes ☐ No

PULMONARY/RESPIRATORY

Condition	Response
Asthma:	☐ Yes ☐ No
COPD/Emphysema:	☐ Yes ☐ No
Lung Disease:	☐ Yes ☐ No
Sleep Apnea:	☐ Yes ☐ No

CHRONIC DISEASE

Condition	Response
Arthritis:	☐ Yes ☐ No
Fibromyalgia Osteopenia / Osteoporosis:	☐ Yes ☐ No
Past History of Cancer:	☐ Yes ☐ No

GASTRO/INTESTINAL

Condition	Response
Crohn's/Ulcerative:	☐ Yes ☐ No
Colitis:	☐ Yes ☐ No
Diverticulitis:	☐ Yes ☐ No
GERD/Hiatal Hernia:	☐ Yes ☐ No
Hepatitis A/B/C:	☐ Yes ☐ No
Irritable Bowel Syndrome:	☐ Yes ☐ No
Liver Disease:	☐ Yes ☐ No
Reflux:	☐ Yes ☐ No
Ulcers:	☐ Yes ☐ No

COMMUNICABLE/INFECTIOUS DISEASE

Condition	Response
AIDS/HIV:	☐ Yes ☐ No
Herpes Simplex:	☐ Yes ☐ No

HEMATOLOGICA

Condition	Response
Anemia:	☐ Yes ☐ No
Deep Venous Thrombosis:	☐ Yes ☐ No
Pulmonary Embolism:	☐ Yes ☐ No

GENITOURINARY

Condition	Response
Benign Prostatic:	☐ Yes ☐ No
Hypertrophy (BPH):	☐ Yes ☐ No

NEUROLOGICAL

Condition	Response
Migraines:	☐ Yes ☐ No
Neurological Disorder:	☐ Yes ☐ No
Parkinson's:	☐ Yes ☐ No
Seizures:	☐ Yes ☐ No

NEPHROLOGY

Condition	Response
Kidney Disease:	☐ Yes ☐ No
Kidney Stones:	☐ Yes ☐ No

GYNECOLOGICAL

Condition	Response
Dysfunctional Uterine:	☐ Yes ☐ No
Bleeding:	☐ Yes ☐ No
Endometriosis:	☐ Yes ☐ No
Polycystic Ovarian Disease:	☐ Yes ☐ No

OTHER

Condition	Response
Gout:	☐ Yes ☐ No
Hives:	☐ Yes ☐ No
Restless Leg Syndrome:	☐ Yes ☐ No

AUTOIMMUNE DISORDERS

Condition	Response
Rheumatoid Arthritis:	☐ Yes ☐ No
Lupus:	☐ Yes ☐ No
Multiple Sclerosis:	☐ Yes ☐ No

CARDIOVASCULAR

Condition	Response
Collagen Vascular Disease:	☐ Yes ☐ No
Coronary Artery Disease /MI or Angina:	☐ Yes ☐ No
Hearth Arrhythmia:	☐ Yes ☐ No
Heart Failure:	☐ Yes ☐ No
High Blood Pressure:	☐ Yes ☐ No
High Cholesterol:	☐ Yes ☐ No
Hypertension:	☐ Yes ☐ No
Pacemaker:	☐ Yes ☐ No
Peripheral Vascular Disease:	☐ Yes ☐ No
Stroke:	☐ Yes ☐ No

DERMATOLOGICAL

Condition	Response
Psoriasis:	☐ Yes ☐ No

ENDOCRINE

Condition	Response
Diabetes:	☐ Yes ☐ No
Thyroid Disorder:	☐ Yes ☐ No
Other Endocrinological Disorder:	☐ Yes ☐ No

PAST HISTORY: Please list the following. If you need additional space, it is provided on the last page. Surgeries (with dates):

ALLERGIES ADVERSE DRUG REACTIONS (types of reactions, be specific)

SR. NO.	ALLERGIES	NATURE OF REACTION	SINCE WHEN

MEDICATIONS: Please list all medications, including prescription, non-prescription, and (including herbal) that you are currently taking. Please include dosage and frequency taken.

SR. NO.	MEDICATION	DOSAGE	FREQUENCY	FOR WHAT CONDITIONS
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

HEALTH HISTORY AND PREVENTATIVE HEALTH MAINTENANCE

Have you:

Ever had a flu vaccine this flu season (Sept-March): ❒Yes ❒No

If yes, When? ____

Have you:

Ever had a blood transfusion: ❒Yes ❒No

If yes, When? ____

REPRODUCTIVE HISTORY:

Number of pregnancies: ____________________ Age at first pregnancy: ______________ Number of hildren:_________________

Did you breast feed? ❒Yes ❒No If yes, how many months? _________________Age at first period: _________________

Age at last period: ___________________ Age at menopause: _____________________ Hysterectomy: ❒Yes ❒No

Ovaries Intact? ❒Yes ❒No If no, please explain ____________________________________ Hormone Use: ❒Yes ❒No

Sex Drive: ❒Yes ❒No Birth Control Method: ______________________________________

Are you taking Estrogen, Birth Control Pills or Testosterone? ❒Yes ❒No

If no, please explain ____

Please provide dates for each answer or write "none".

Last Mammogram: ______________________ Last Breast MRI: ______________________________
Last Bone Density Scan: ______________________ Last Upper Endoscopy: ______________________________
Last Prostate Exam: ______________________ Last Pap Smear: ______________________________
Last Breast Biopsy: ______________________ Last Colonoscopy: ______________________________
Last Pneumonia Vaccine: ______________________ Last PSA Screening: ______________________________
Last screening chest CT: ______________________

SOCIAL & ENVIRONMENTAL REVIEW (If yes, please fill out type, qty, how often, etc.)

Do you drink alcoholic beverages: ❒Yes ❒No How many drinks per week/months: ________________________

Have you ever smoked cigarettes: ❒Yes ❒No Are you currently smoking ❒Yes ❒No

Packs per day? _________________ How many years? _____________________ When did you quit? ________________

Do you use consume tobacco any other from ❒Cigar ❒Chewing Tobacco?

Do you use caffeine? ❒Yes ❒No What caffeinated beverages? ______________________________

Do you use recreational drugs? ❒Yes ❒No How often? __________________ How much? ______________

What type? _______________________________ If quit, when? ____

What is your highest education? ❒High school ❒Some college ❒College graduate ❒Advanced degree

Marital Status ❒Married ❒Single ❒Widowed ❒Divorced

With whom do live? ___________________________________ Occupation? ____________________________________

FAMILY HISTORY: Please list any illnesses in your family, including all cancers (e.g., breast cancer, colon cancer, ovarian cancer, etc.) and blood disorders (e.g., anemia, blood clotting disorders, etc.).

RELATIONSHIP	IF YES, WHICH CANCER OR BLOOD DISORDER	AGE AT DIAGNOSIS	ARE THEY DECEASED?
Mother: ❒Yes ❒ No			
Brothers: ❒Yes ❒ No			
Father: ❒Yes ❒ No			
Sisters: ❒Yes ❒ No			
Cousins: ❒Yes ❒ No			
Children: ❒Yes ❒ No			
Grandmother (P) ❒Yes ❒ No			
Grandfather (P): ❒Yes ❒ No			
Grandmother (M): ❒Yes ❒ No			
Grandfather (M): ❒Yes ❒ No			
Aunts (M): ❒Yes ❒ No			
Aunts (P): ❒Yes ❒ No			
Uncles (M): ❒Yes ❒ No			
Uncles (P): ❒Yes ❒ No			

SYMPTOMS: Please list any symptoms you may have in the categories below.

CONSTITUTIONAL
- Weight Loss: ☐ Yes ☐ No
- Poor Energy Level: ☐ Yes ☐ No
- Fever: ☐ Yes ☐ No
- Chills: ☐ Yes ☐ No
- Night Sweats: ☐ Yes ☐ No

ENT/MOUTH
- Ringing in Ears: ☐ Yes ☐ No
- Oral Ulcers: ☐ Yes ☐ No
- Nasal Drip: ☐ Yes ☐ No
- Hearing Loss: ☐ Yes ☐ No
- Bleeding Gums: ☐ Yes ☐ No
- Mouth Pain: ☐ Yes ☐ No
- Nose Bleeds: ☐ Yes ☐ No
- Sore Throat: ☐ Yes ☐ No
- Difficulty Swallowing: ☐ Yes ☐ No
- Hoarseness: ☐ Yes ☐ No
- Sinus Pain: ☐ Yes ☐ No

EYES (CONT.)
- Vision Loss: ☐ Yes ☐ No
- Flashing Lights: ☐ Yes ☐ No

RESPIRATORY
- Cough: ☐ Yes ☐ No
- Wheezing: ☐ Yes ☐ No
- Shortness of Breath: ☐ Yes ☐ No
- Coughing Blood: ☐ Yes ☐ No
- Pain w/Breathing: ☐ Yes ☐ No

GYNECOLOGICAL
- Vaginal Discharge: ☐ Yes ☐ No
- Pelvic Pain: ☐ Yes ☐ No
- Vaginal Dryness: ☐ Yes ☐ No
- Unexplained or Heavy Bleeding: ☐ Yes ☐ No

GASTROINTESTINAL
- Vomiting: ☐ Yes ☐ No
- Jaundice: ☐ Yes ☐ No
- Abdominal Pain: ☐ Yes ☐ No
- Maroon/Black Stool: ☐ Yes ☐ No
- Constipation: ☐ Yes ☐ No
- Abdominal Cramping: ☐ Yes ☐ No
- Diarrhoea: ☐ Yes ☐ No
- Vomiting Blood: ☐ Yes ☐ No
- Change in Swallowing: ☐ Yes ☐ No
- Nausea: ☐ Yes ☐ No

MUSCULOSKELETAL
- Muscle Pain: ☐ Yes ☐ No
- Spine Tenderness: ☐ Yes ☐ No
- Swollen Joints: ☐ Yes ☐ No
- Joint Redness: ☐ Yes ☐ No

BREAST
- Mass: ☐ Yes ☐ No
- Pain: ☐ Yes ☐ No
- Nipple Discharge: ☐ Yes ☐ No
- Change in size: ☐ Yes ☐ No
- Change in Shape: ☐ Yes ☐ No

NEUROLOGICAL
- Confusion: ☐ Yes ☐ No
- Seizures: ☐ Yes ☐ No
- Fainting Spells: ☐ Yes ☐ No
- Tremors: ☐ Yes ☐ No
- Speech Change: ☐ Yes ☐ No
- Headache: ☐ Yes ☐ No
- Hiccups: ☐ Yes ☐ No
- Abnormal Gait: ☐ Yes ☐ No
- Weakness in Upper Extremity: ☐ Yes ☐ No
- Weakness in Left Side: ☐ Yes ☐ No
- Weakness of Lower Extremity: ☐ Yes ☐ No
- Weakness in Right Side: ☐ Yes ☐ No
- Sensory Change: ☐ Yes ☐ No
- Abnormal Numbness /Tingling: ☐ Yes ☐ No

CARDIOVASCULAR
- Chest pain or Pressure upon Exertion: ☐ Yes ☐ No
- -If yes explain:_______________
- Arm/Leg Swelling: ☐ Yes ☐ No
- Palpitations: ☐ Yes ☐ No
- Calf Discomfort: ☐ Yes ☐ No
- Fainting Spells: ☐ Yes ☐ No
- Arm Swelling: ☐ Yes ☐ No

URINARY
- Painful Urination: ☐ Yes ☐ No
- Blood in Urine: ☐ Yes ☐ No
- Increase Frequency: ☐ Yes ☐ No
- Loss of Control: ☐ Yes ☐ No
- Impotence: ☐ Yes ☐ No

PSYCHIATRIC
- Depression: ☐ Yes ☐ No
- Anxiety: ☐ Yes ☐ No
- Lack of Concentration: ☐ Yes ☐ No

ENDOCRINE
- Excessive Urine: ☐ Yes ☐ No
- Excessive Thirst: ☐ Yes ☐ No
- Hot Flashes: ☐ Yes ☐ No
- Heat Intolerance: ☐ Yes ☐ No
- Cold Intolerance: ☐ Yes ☐ No

HEMATOLOGICAL
- Nose Bleeds: ☐ Yes ☐ No
- Bleeding Gums: ☐ Yes ☐ No
- Purple Spots on Hands: ☐ Yes ☐ No
- Bruising: ☐ Yes ☐ No

LYMPHATIC
- Enlarged Lymph Nodes: ☐ Yes ☐ No
- Swelling in Arms: ☐ Yes ☐ No

SKIN
- Rash: ☐ Yes ☐ No
- Nodules: ☐ Yes ☐ No
- Itchiness: ☐ Yes ☐ No
- Lesions: ☐ Yes ☐ No

REFERRING PHYSICIANS: Please list all referring physicians and those you are currently seeing.

PHYSICIAN	ADDRESS	PHONE NUMBER	SPECIALITY

PHARMACY: Please list your pharmacy information.

PHARMACY	ADDRESS	PHONE NUMBER

ADVANCE DIRECTIVE

Do have an Advance Directive, also known as a Living Will? ❐Yes ❐No

If yes, please provide us with a copy for our medical record.

If you were ever unable to speak for yourself, who would the doctors speak to on your behalf (Healthcare proxy)?

Name: ________________________________ **Phone:** ______________________________

Patient Signature: _________________________ **Date:** ________________________________

Medical Record No - Patient Name: -