VIRGIN ISLANDS ONCOLOGY HEMATOLOGY

Patient name: ______________________ **Maiden Name:** __________ **MR #:** ____________ **Date:** __________

Date of birth: ______________________ **Social security #:** ______________________

Mailing address: ____

Home phone: ______________ **Work phone:** ______________ **Cell phone:** ______________

Employer: ____

Emergency contact: ______________ **Relationship:** ______________ **Phone:** ______________

Chief complaint: (Why have you been referred to our office?) ______________________________

Referring doctor: ______________ **Telephone:** ______________ **Primary doctor:** ______________

Other doctors that provide care: ______________________________

Preferred pharmacy: ______________________ **Phone #:** ______________

Medications: Please list all the medications you are currently taking, including the dosage and frequency. If necessary, please continue your list on another sheet.

______________________ ______________________

______________________ ______________________

______________________ ______________________

Drug allergies: Please list and include reactions (rash, hives, breathing problems, etc.)

☐ Check if you have an allergy to the contrast used in radiology procedures.

______________________ ______________________

______________________ ______________________

MEDICAL ILLNESS: Please check all that apply.

NERVOUS SYSTEM

- ☐ Stroke / TIA
- ☐ Seizures
- ☐ Severe Anxiety
- ☐ Depression

SENSES

- ☐ Hearing loss / deafness
- ☐ Vision loss / blinded
- ☐ Glaucoma / cataracts

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Angina, heart attack
- ☐ Congestive heart failure
- ☐ Abnormal heart rhythm
- ☐ High cholesterol
- ☐ Peripheral vascular disease
- ☐ Cardiac stents

LUNGS

- ☐ Asthma
- ☐ Emphsema / COPD

GASTROINTESTINAL

- ☐ Ulcers, reflux, gastritis
- ☐ Colitis / diarrhea
- ☐ Liver Disease

BONES / JOINTS

- ☐ Arthritis
- ☐ Fractures
- ☐ Joint Replacements

ENDOCRINE

- ☐ Diabetes
- ☐ Thyroid - ☐ High ☐ Low

INFECTIONS

- ☐ HIV / AIDS
- ☐ Hepatitis

KIDNEYS

- ☐ Kidney failure
- ☐ Kidney stones

BLOOD DISORDERS

- ☐ Anemia
- ☐ Abnormal blood counts
- ☐ Clotting problems
- ☐ Bleeding problems

CANCER

- ☐ Current diagnosis (type): ______________________
- ☐ Previous diagnosis (when, type): ______________________

Surgical procedures:

______________________ ______________________

______________________ ______________________

Family history: If any family member has had cancer, please note what type and their relationship to you.

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Social History: Married: ☐ Yes ☐ No Divorced: ☐ Yes ☐ No
Widow(er): ☐ Yes ☐ No Separated: ☐ Yes ☐ No

Who lives with you? ______________________

Cigarettes:

Are you or have you ever been a smoker? ☐ Yes ☐ No If "yes", when did you start? ____________

Have you stopped smoking? ☐ Yes ☐ No If "yes", when did you stop? ____________

If "no", would you like help quitting smoking? ☐ Yes ☐ No

Other tobacco: ☐ Pipe ☐ Cigars ☐ Snuff ☐ Chewing tobacco

Alcohol use: ☐ Yes ☐ No ☐ If yes, how many drinks per week?

Illegal drugs: ☐ Yes ☐ No ☐ If yes, explain.

Symptoms:	Currently	In the Past		Currently	In the Past
Shortness of breath	☐	☐	Cough	☐	☐
Easy bruising / bleeding	☐	☐	Chest pain	☐	☐
Abdominal pain	☐	☐	Diarrhea	☐	☐
Bloody stool	☐	☐	Nausea	☐	☐
Fevers	☐	☐	Vomiting	☐	☐
Night sweats	☐	☐	Fatigue	☐	☐
Difficulty emptying bladder	☐	☐	Dizziness	☐	☐
Numbness	☐	☐	Poor appetite	☐	☐

Weight loss: How much, if any, in the last 6 months? ____________

Pain: Describe location, intensity and what makes it worse or better. ______________________

Please describe any other important symptoms. ______________________

Are you having any difficulty coping with your diagnosis related depression or anxiety? ☐ Yes ☐ No

Primary Insurance Information ** All information MUST be filled out**

Insurance Company: ____________ Address: ____________

Insured's name: ____________ Relationship to insured: ☐ Self ☐ Spouse ☐ Other

Date of birth: ____________ Social security # ____________

Insured ID#: ____________ Group # ____________

Secondary Insurance Information ** All information MUST be filled out (if applicable)**

Insurance Company: ____________ Address: ____________

Insured's name: ____________ Relationship to insured: ☐ Self ☐ Spouse ☐ Other

Date of birth: ____________ Social security # ____________

Insured ID#: ____________ Group # ____________

I hereby authorize Virgin Islands Oncology & Hematology to furnish my medical records to insurance carriers and physicians assisting in my care, concerning my illness and treatments. I hereby assign Virgin Islands Oncology & Hematology all payments for medical service rendered to dependents or myself. I understand that these authorizations remain in effect as long as my dependent or I remain a patient.

Patient Signature: ______________________ Date: ____________

Relationship, if other than patient: ______________________