AMY McMULLEN, M.D.
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Central Coast Oncology & Hematology
1669 Dominican Way
Santa Cruz, CA 95065
Phone: 831-475-2220; Fax: 831-475-2221

Patient Name _____

Date _____

Please list other physicians you see and their specialties (e.g., PCP, cardiologist, etc.):

Name	Speciality

Medical History

Medical (For example: High Blood Pressure, Diabetes, Heart Disease, etc.) None ☐

Surgical (For example: Tonsillectomy, Appendectomy, Hysterectomy, Hernia repair, Cholecystectomy, etc.) None ☐

Allergies to medications (If yes, please explain type of reaction, for example: hives, wheezing, upset stomach, swelling, etc.) None ☐

Current prescription medications None ☐

drug name	mg. dose	#tablets	# per day	drug name	mg. dose	#tablets	# per day

Over-the-counter medications (For example: Tylenol, Ibuprofen, Aleve, aspirin, vitamins, herbals, etc.) None ☐

Family History (Have any of your family members been diagnosed with any types of cancer? Please indicate cancer type and age at diagnosis. Also indicate any bleeding, clotting or other blood disorders.) None ☐

Mother _____
Father _____
Sibling _____
Sibling _____
Children _____
Maternal aunt/uncle _____
Maternal grandmother _____
Maternal grandfather _____
Maternal 1st cousins _____
Paternal aunt/uncle _____
Paternal grandmother _____
Paternal grandfather _____
Paternal 1st cousins _____
Other family members with disorders of concern _____

Physician Signature _____ Date _____

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Patient Name _____

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Social History

Have you ever smoked cigarettes? Yes ☐ No ☐ If yes, _____ packs per day for _____ years. Quit date: _____

Do you currently drink alcohol? Yes ☐ No ☐ If yes, _____ drinks per day, _____ drinks per week.

What type(s) of alcohol do you drink?_____ Has stopping alcohol ever been a problem for you? Yes ☐ No ☐

Have you ever used IV drugs? Yes ☐ No ☐ Date of last use: _____

Have you ever had a blood transfusion? Yes ☐ No ☐ Date of last transfusion: _____

Marital Status: _____ Number of children _____, number of grandchildren _____.

Who currently lives with you? _____

Who does most of your cooking and cleaning? _____

Current and past occupations: _____

Any occupational or environmental exposures? Yes ☐ No ☐ If yes, type: _____

_____

For Women Only:

# of pregnancies _____, # of births _____, # of children breastfed _____, length of breastfeeding _____

Age at first period _____. Did you ever receive hormonal fertility treatments? Yes ☐ No ☐

Have you ever taken birth control pills? Yes ☐ No ☐ **# of years taken**_____.

Approximate date of last menstrual period_____. **Age at menopause** _____.

Have you ever taken hormone replacement therapy? Yes ☐ No ☐ **# of years taken** _____. **Current use?** Yes ☐ No ☐

Date hormones were stopped _____. **Please list any hormone-containing products you are currently using (i.e. birth control pills, hormone-emitting IUD's, vaginal preparations, estrogen/testosterone creams, etc.).** _____

Review of Systems

Have you recently experienced any of the following? Circle all that apply.

CONSTITUTIONAL: recent, unintentional weight loss or weight gain (If so, how much and over what period of time?) _____ _____, loss of appetite, fevers, drenching night sweats, profound fatigue. (If so, give an example of something you could do previously but now cannot do because of your fatigue.) _____

EYES: blurry vision, double vision, loss of vision, eye pain.

EARS/NOSE/THROAT/MOUTH: mouth sores, sore throat, sinus problems, ear infections.

RESPIRATORY: shortness of breath, cough, wheezing.

CARDIOVASCULAR: chest pain, irregular heart beats.

GASTROINTESTINAL: nausea, vomiting, indigestion/heartburn, diarrhea, constipation, blood in stools, black/tarry stools.

GENITOURINARY: urinary retention, painful urination, frequent urination, blood in urine.

MUSCULOSKELETAL: neck pain, back pain, painful or swollen joints. Indicate which joints: _____

NEUROLOGIC: headaches, tremors, dizzy spells, numbness/tingling. Indicate where: _____

PSYCHIATRIC: depression, anxiety, unusual irritability, changes in sleep pattern. Describe: _____

ENDOCRINE: excessive thirst, feeling too hot/cold, changes in skin/hair/nails.

LYMPHATICS: enlarged lymph nodes, painful lymph nodes.

SKIN: rashes, persistent itching.

Physician Signature _____ Date _____