SUBURBAN HEMATOLOGY-ONCOLOGY ASSOCIATES
AFFILIATED WITH NORTHSIDE HOSPITAL CANCER INSTITUTE

PLACE LABEL HERE

Patient Information Form

Patient's Name (LAST)(FIRST)(MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX : ☐ MALE ☐ FEMALE
Street Address	City	State	Zip
County	Home Phone	Cell Phone	Work Phone
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life Partner	Email Address:		
Employment Status: ☐ Full Time ☐ Part-Time ☐ Retired ☐ Active Military ☐ Unemployed ☐ Self Employed Retirement Date: _____	Employer Name/Address:		
Preferred Language	Interpreter Needed: ☐ YES ☐ NO		

Nationality: Circle One - Asian Black/African American Caucasian Hispanic or Latino Native Hawaiian or Other Pacific Islander American Indian or Alaska Native

Other _____ Unknown or Not Reported

EMERGENCY CONTACT		PHONE	
PHARMACY NAME/ADDRESS		PHONE	
REFERRING PHYSICIAN/ADDRESS		PHONE	
PRIMARY CARE PHYSICIAN/ADDRESS		PHONE	
NAME OF PRIMARY INSURANCE/PHONE NO:		NAME OF SECONDARY INSURANCE/PHONE NO.	
NAME OF INSURED	RELATIONSHIP TO PATIENT	NAME OF INSURED	RELATIONSHIP TO PATIENT
INSURED SS#	INSURED DOB	INSURED SS#	INSURED DOB
EMPLOYER NAME		EMPLOYER NAME	
GROUP NAME/NO.		GROUP NAME/NO.	
POLICY/CERTIFICATE/ID NO.		POLICY/CERTIFICATE/ID NO.	

Acknowledgement: I acknowledge all information above is accurate. (Please ONLY sign the next available).

Signature of Patient or Parent/Guardian (if a minor) or Power of Attorney	Date	Employee Initials
Sign at Annual Update, if no changes	Date	Employee Initials
Sign at Annual Update, if no changes	Date	Employee Initials

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PATIENT HISTORY

NAME: _____ **DATE:** _____

PATIENT PROFILE

Place of birth: _____ Highest Grade Completed: _____
Occupation: _____ Religion: _____
Tobacco use: _____ Alcohol use: _____

PAST MEDICAL HISTORY (Check if appropriate)

❑ Skin cancer	❑ Ulcer	❑ Heart attack	❑ Arthritis
❑ Thyroid disease	❑ Hepatitis	❑ Other heart disease	❑ Head injury
❑ Diabetes	❑ Intestinal disease	❑ Lung disease	❑ Cancer
❑ Pneumonia	❑ Gallbladder disease	❑ High blood pressure	❑ Phlebitis
❑ Tuberculosis	❑ Kidney/bladder disease	❑ Stroke	❑ Asthma
❑ Blood transfusion	❑ Venereal disease	❑ Seizures	❑ High cholesterol

LIST ALL MEDICATIONS

	Drug	Dose	Frequency
1.			
2.			
3.			
4.			
5.			

LIST ALL PROCEDURES

	Procedure	Date	Hospital
1.			
2.			
3.			
4.			
5.			

ALLERGIES ☐ **NONE** ☐ **DYE** ☐ **LATEX**

☐ **DRUG: Please List Drug and Reaction:** _____

☐ **Other: Please List with Reaction**: _____

FAMILY HISTORY

	If Living		If Deceased	
	Age	Health	Age at death	Cause
Father:				
Mother:				
Brother/Sister:				
Husband/Wife:				
Children				

PATIENT HISTORY

Have any blood relatives ever had? (Check if appropriate)

❑ Cancer ❑ Heart disease ❑ Other: _____
❑ Bleeding disorder ❑ Diabetes _____
❑ Anemia ❑ Kidney disease _____

Have you had any of these in the last three months?

NO		YES
	GENERAL	
❑	Change in weight	❑
❑	Fever / Chills	❑
❑	Night sweats	❑
	SKIN	
❑	Itching	❑
❑	Rash	❑
❑	Change in mole	❑
	GLANDS	
❑	Heat / cold intolerance	❑
❑	X-ray treatments to neck	❑
❑	Excessive thirst / urination	❑
	EENT	
❑	Change in vision	❑
❑	Double vision	❑
❑	Difficulty hearing	❑
❑	Frequent bloody nose	❑
❑	Sinus infection	❑
❑	Hoarseness	❑
❑	Ringing in ears	❑
❑	Sores in mouth	❑
	HEART / LUNGS	
❑	Chest pain	❑
❑	Cough	❑
❑	Coughing blood	❑
❑	Shortness of breath	❑
❑	Wheezing	❑
❑	Irregular / racing heartbeat	❑
❑	Black out spells	❑
❑	Ankle swelling	❑
❑	Aching in legs when walking	❑
	BLOOD	
❑	Anemia	❑
❑	Unusual dietary craving	❑
❑	Excessive bruising / bleeding	❑
❑	Enlarged lymph nodes	❑

NO		YES
	INTESTINAL	
❑	Nausea / Vomiting	❑
❑	Vomiting blood	❑
❑	Difficulty swallowing	❑
❑	Abdominal pain / swelling	❑
❑	Yellow jaundice	❑
❑	Blood in stool / black stool	❑
❑	Diarrhea / constipation	❑
❑	Change in bowel habits	❑
	URINARY	
❑	Burning / painful urination	❑
❑	Blood in urine	❑
❑	Nighttime urination	❑
❑	Change in urine stream	❑
❑	Sores on genitals	❑
	SKELETAL	
❑	Joint pain / stiffness	❑
❑	Back pain	❑
	NEUROLOGICAL	
❑	Frequent / severe headache	❑
❑	Numbness / tingling	❑
❑	Incoordination	❑
❑	Limb weakness	❑
❑	Psychiatric illness	❑
❑	Unusual anxiety / depression	❑
❑	Drug / Alcohol addiction	❑
	FOR WOMEN	
❑	Bleeding between periods	❑
❑	Bleeding since menopause	❑
❑	Pain in female organs	❑
❑	Breast lump / pain	❑
❑	Nipple discharge	❑
	FOR MEN	
❑	Lump / pain in testicle	❑
❑	Impotence	❑
❑	Discharge	❑

PATIENT HISTORY

LEARNING BARRIERS - ☐ NONE

Please check all that apply

☐ **Cognitive**	☐ **Cultural Issues**
☐ **Emotional State**	☐ **Unable to Read**
☐ **Medically Unstable**	☐ **Motivation**
☐ **Physical Limitation**	☐ **Other** _____

LEARNING PREFERENCES

☐ **Verbal/Listening**	☐ **Written/Reading**
☐ **Demonstration**	☐ **No Preference**

SOCIAL

Do you feel safe returning home? ☐ Yes ☐ No

Do you feel that you have been abused, neglected or exploited by someone close to you? ☐ Yes ☐ No

Do you need help with personal/financial, social problems, obtaining your medications or supplies? ☐ Yes ☐ No

Completed by: _____ Relationship to patient: _____

Form Reviewed by: _____ Date/Time: _____