Central Coast Oncology & Hematology

Amy McMullen, MD Michael Yen, MD PhD

Medical History

Patient Name: (Last, First) _____

Date of Birth:_____

Current prescription medications ⬜ None							
Drug name	Dose	# tablets	# per day	Drug name	Dose	# tablets	# per day

Preferred pharmacy:_____

Over-the-counter medications:(examples: Tylenol, aspirin, vitamins, herbals, etc.) ⬜ None

_____

Allergies (List medications or foods you are allergic to and what happens when you take them.) ⬜ None

_____

_____

Family history of cancer and blood disorders: Have any of your family members been diagnosed with any types of cancer or blood disorders? Please indicate type and age at diagnosis.	
Mother	Paternal aunt/uncle
Father	Paternal grandmother
Sibling	Paternal grandfather
Sibling	Paternal 1st cousins
Children	Other family members with disorders of concern
Maternal aunt/uncle	
Maternal grandmother	
Maternal grandfather	
Maternal 1st cousins	

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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.

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

Have you ever used recreational 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 & cleaning? _____

Current & past occupations:_____

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

This section is 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 or used other methods of hormonal birth control? ☐ *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 of hormones ☐ *Yes* ☐ *No* *Date hormones were stopped* _____

Please list any hormone-containing products you are currently using (ex: birth control pills, IUD's, creams, etc.)

_____

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