MEDICAL HISTORY FORM

Utah Hematology Oncology, P.C.
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Name: _____
Date of Birth:_____
Age: _____
Today's Date: _____

REASON FOR REFERRAL:_____
_____
_____
_____

REFERRING DOCTOR:_____
_____

PRIMARY DOCTOR:_____
_____

MEDICATIONS: (please list all prescription and non-prescription medications, dose and # taken each day)
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES: (list any allergies to medicines or contrast material such as iodine)_____
_____
_____
_____

MEDICAL PROBLEMS: (i.e. diabetes, hypertension, heart disease, lung disease, kidney or liver problems, previous cancer)
_____
_____
_____
_____
_____
_____
_____

SURGERY: (list any surgical procedures you have undergone and approximate year)
_____
_____
_____
_____
_____
_____

OBSTETRICAL HISTORY:
Last menstrual period:_____
Age of menopause if applicable:_____
Number of pregnancies:_____
Age of 1st pregnancy:_____
Number of Miscarriages:_____
Have you taken hormonal supplementation such as estrogen or progesterone?_____
If yes, how many years?_____
When did you stop?_____

FAMILY HISTORY: (list any significant medical problems such as cancer or blood diseases with your family)
Mother (alive/deceased)_____
Father (alive/deceased)_____
Brothers_____
Sisters_____
Other (specify)_____

SOCIAL HISTORY:
Marital status_____
Number of children if any_____
Current or past occupation_____
_____
Did or do you drink alcohol?_____
(if yes, how much per week?)_____
(if no, when did you quit?)_____
Did or do you smoke?_____
(if yes, how many packs/day?)_____
(if no, when did you quit?)_____