MICHIANA HEMATOLOGY-ONCOLOGY, P.C.
MICHIANA HEMATOLOGY-ONCOLOGY OF MICHIGAN, P.C.
PATIENT DATA RECORD

Date_____ Ht._____ Wt._____

Patient Name:	Like to be called:	DOB/Age:
Home Phone Number:	Sex: M F	Marital Status: M S D W
Spouse Name:	Spouse Day Phone:	
Employer:	Emergency Contact Person:	
Employer Phone Number:	Relationship:	
Spouse Employer:	Address:	
Employer Phone Number:	Contact Phone Number:	

MEDICAL / SOCIAL HISTORY

CURRENT MEDICAL			CURRENT MEDICATIONS		
ALLERGIES			Medications / Vitamins / Herbals	Dose	Frequency
Health History: (list any health problems and past surgeries)					
			Do you have a Drug Card?		
			What pharmacy do you prefer?		
Have you ever had chemotherapy?	Yes	No	Pharmacy Phone Number:		
Have you ever had Radiation Therapy?	Yes	No	Do you follow a special diet?		
			FAMILY CANCER HISTORY		
Do you perform monthly self breast exams?	Yes	No	Mother:		
Do you perform monthly testicular exams?	Yes	No	Father:		
Date of Last Physical:			Siblings:		
Date of Last Mammogram:			Tobacco: Yes No # Packs/Day:		
Date of Last Pap:			Date Quit Tobacco:		
Date of Last Rectal Exam:			Alcohol: Yes No Frequency of Alcohol:		
Do you have a living will?	Yes	No	Date Quit Alcohol:		
List any Doctors involved in your care:					

MD TO COMPLETE:

Diagnosis_____ Stage_____ MD Signature_____