LAKE NORMAN HEMATOLOGY ONCOLOGY SPECIALISTS

Current Medications

Patient Name _____ D.O.B. _____ MR# _____

1. Current Medications:
List the medications you are currently taking (Prescription and non-Prescription)

Medication Name	Dose	Times Per Day

2. Allergies
List any medications or other substances to which you are allergic (i.e. pollen, food, tape, latex, etc.)

Medication or Substance	Allergic Reaction

3. Past Medical History:
List any medical illnesses that you have or have had in the past (i.e. heart attack, heart failure, high blood pressure, emphysema, etc.)

Illness	Date (Approximate Month/Year)

(Medical History Continued) **MR # _____**

List any prior surgeries or procedures

Surgery/Procedure	Date (Approximate Month/Year)

- **When was your last Colonoscopy? _____**
- **When was your last Mammogram? _____**

Reproductive History for Women:

- **Approximately at what age did you begin having periods? _____**
- **How many children have you had? _____**
- **How old were you when your first child was born? _____**
- **Have you had any miscarriages? ○ Yes ○ No If yes, how many? _____**
- **Have you gone through menopause? ○ Yes ○ No If yes, approximately how old were you? _____**
- **Have you had a hysterectomy? ○ Yes ○ No**
- **If yes, how old were you? _____ Were your ovaries removed? ○ Yes ○ No**
- **Have you at any time taken hormone replacement therapy? ○ Yes ○ No**
- **If yes, what did you take and for how long? _____**

4. Family History

List any major illnesses that run in your family.

Illness	Relationship

Habits

- **Do you smoke or have you ever smoked cigarettes? ○ Yes ○ No**
- **If yes, how much and for how long? _____**
- **If you have quit smoking, when did you quit? _____**
- **Do you use other tobacco products? _____**
- **Do you drink alcohol? ○ Yes ○ No ● If yes, how much and how often? _____**