

**Please complete this form
and bring it with you to
your appointment.**

**ONCOLOGY
HEMATOLOGY**
ASSOCIATES
OF SPRINGFIELD, M.D. P.C.

OHA # _____

William F. Cunningham, M.D. Robert J. Ellis, M.D. Kerry J. Williams, M.D. Brooke Gillett, D.O. Jiantao Ding, M.D.

HEALTH QUESTIONNAIRE

Name _____ Date _____

Referred By _____ Personal Physician _____

Reason for this Visit: _____

Do you have an Advanced Health Care Directive? (Someone appointed to make health care decisions for you.)

Yes No If yes, please provide our office with a copy.

Current Medications (Include NON-Prescription)

Name of Medicine	Strength of Dose (MG.)	How Often Taken	Reason Taken

Allergies (Food and Medication) **Rate the severity of each allergy (1 to 6)**
1 - Mild; 2 - Mild to Moderate; 3 - Moderate; 4 - Moderate to Severe; 5 - Severe; 6 - Fatal

Medical History

Surgeries: Date/Operation

Other Hospitalizations, Injuries, or Illnesses: Date/Reason

Other Medical Illnesses

Heart Disease Lung Disease Thyroid Disease
 Diabetes Hypertension Other _____

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Family History

	Current Age	Age At Death	Illness/Cause of Death
Father			
Mother			
Brothers			
Sisters			

	Current Age	Age At Death	Illness/Cause of Death
Spouse			
Children			

Check Illnesses of Blood Relatives - Specify Who:

- Cancer _____
- Heart Disease _____
- Diabetes _____

- (Type) _____
- Hypertension _____

Social History

Married Single Divorced Widowed

Occupation _____

Habits

Cigarette Use: Never Former Current
Date Started: _____ Date Stopped _____

Cigar Use: Never Former Current
Date Started: _____ Date Stopped _____

Pipe Use: Never Former Current
Date Started: _____ Date Stopped _____

Chewing Tobacco: Never Former Current
Date Started: _____ Date Stopped _____

Amount of Alcohol: Never Former Occasional Frequent Daily
Drinks per day: _____

Substance Use: Never Former Current

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Please Check Yes or No

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	General
<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Change _____ Lbs. Gain/Lost
<input type="checkbox"/>	<input type="checkbox"/>	Decreased Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Fever: Maximum Temperature _____
<input type="checkbox"/>	<input type="checkbox"/>	Nightsweats
<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Skin Changes: _____

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Head and Neck
<input type="checkbox"/>	<input type="checkbox"/>	Change in Vision
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears
<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds
<input type="checkbox"/>	<input type="checkbox"/>	Nasal / Sinus Congestion
<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth
<input type="checkbox"/>	<input type="checkbox"/>	Persistent Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	Mouth Sores

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Daily Cough
<input type="checkbox"/>	<input type="checkbox"/>	Blood in Sputum
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing / Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease / COPD
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Positive TB Skin Test

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Heart and Circulation
<input type="checkbox"/>	<input type="checkbox"/>	Chest Discomfort/ Tightness / Pain
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat / Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath When Lying Down
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath With Exertion
<input type="checkbox"/>	<input type="checkbox"/>	History of Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	Edema
<input type="checkbox"/>	<input type="checkbox"/>	Leg/Calf Pain Tenderness

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Stomach and Bowels
<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn / Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain / Discomfort
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease
<input type="checkbox"/>	<input type="checkbox"/>	Change in Bowel Habits
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea / Frequent Loose Stools
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Black or Bloody Stools
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice/Hepatitis

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Kidneys and Bladder
<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine
<input type="checkbox"/>	<input type="checkbox"/>	History of Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Nighttime Urination: _____ Times Per Night
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Daytime Urination
<input type="checkbox"/>	<input type="checkbox"/>	Discomfort on Urination
<input type="checkbox"/>	<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	History of Urinary Infections

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Men
<input type="checkbox"/>	<input type="checkbox"/>	Penile Sores or Discharge
<input type="checkbox"/>	<input type="checkbox"/>	Testicular Pain or Lumps
<input type="checkbox"/>	<input type="checkbox"/>	Impotence
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Infection

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Women
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual History
<input type="checkbox"/>	<input type="checkbox"/>	Age of Onset _____ Last Period _____
<input type="checkbox"/>	<input type="checkbox"/>	Date of Bone Density _____
<input type="checkbox"/>	<input type="checkbox"/>	Last Pap Smear _____ Normal / Abnormal
<input type="checkbox"/>	<input type="checkbox"/>	Number of Pregnancies _____
<input type="checkbox"/>	<input type="checkbox"/>	Number of Miscarriages _____
<input type="checkbox"/>	<input type="checkbox"/>	Number of Abortions _____
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods
<input type="checkbox"/>	<input type="checkbox"/>	Heavy Menstrual Flow / Clotting
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge / Itching

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Please Check Yes or No

YES NO

Breast

<input type="checkbox"/>	<input type="checkbox"/>	Lump in Breasts
<input type="checkbox"/>	<input type="checkbox"/>	Nipple Discharge
<input type="checkbox"/>	<input type="checkbox"/>	Date of Last Mammogram _____
<input type="checkbox"/>	<input type="checkbox"/>	Perform Monthly Breast Self-Exams

DR _____

Patient Name: _____

DOB: _____

Bones and Joints

<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain
<input type="checkbox"/>	<input type="checkbox"/>	Morning Joint Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Back Injury
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Gout

Blood

<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising / Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands

Nervous System

<input type="checkbox"/>	<input type="checkbox"/>	History of Head Injury
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Consciousness
<input type="checkbox"/>	<input type="checkbox"/>	Blacking Out
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Seizures / Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Tremors / Shakes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Walking
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Writing
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Speaking
<input type="checkbox"/>	<input type="checkbox"/>	Memory Problems or Confusion

Endocrine

<input type="checkbox"/>	<input type="checkbox"/>	Heat/Cold Intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Sweating
<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes

Psychiatric

<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Falling or Staying Asleep
<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks
<input type="checkbox"/>	<input type="checkbox"/>	Depression / Frequent Unhappiness
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety