Hematology & Oncology
RHODE ISLAND

PATIENT INFORMATION REGISTRATION FORM

Name: _____ Age: _____ DOB: _____

Primary Physician: _____Referred by: _____

Reason for Visit: _____

MEDICAL PROBLEMS: Please check all that apply.

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Lung Disease
- ☐ Sinusitis
- ☐ Thyroid Disease
- ☐ Heart Disease
- ☐ Frequent Infections
- ☐ Anemia
- ☐ Stroke
- ☐ Blood Clots

☐ Other (please explain): _____
☐ Surgeries (describe/date): _____
_____
☐ Allergies: _____
☐ Blood Transfusion (include date): _____

SOCIAL:

SMOKING ☐ N ☐ Y _____packs/day
ALCOHOL ☐ N ☐ Y _____drinks/week

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower

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FAMILY HISTORY:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Blood Disorder (type): _____
- ☐ Cancer (type): _____

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PATIENT INFORMATION REGISTRATION FORM

REVIEW OF SYMPTOMS: Have any of the symptoms listed below recently been a significant problem to you? Please CHECK either YES or NO.

Weight Loss	Y ☐	N ☐	Chest Pain	Y ☐	N ☐
Night Sweats	Y ☐	N ☐	Varicose Vein	Y ☐	N ☐
Fever	Y ☐	N ☐	Sleep Patterns Normal	Y ☐	N ☐
Chills	Y ☐	N ☐	Skin Rash	Y ☐	N ☐
Headache	Y ☐	N ☐	Itch	Y ☐	N ☐
Blurred Vision	Y ☐	N ☐	Joint Pain	Y ☐	N ☐
Double Vision	Y ☐	N ☐	Neck Pain	Y ☐	N ☐
Hay Fever	Y ☐	N ☐	Back Pain	Y ☐	N ☐
Drug Allergies	Y ☐	N ☐	Other Pain	Y ☐	N ☐
Tremors	Y ☐	N ☐	Ear Infection	Y ☐	N ☐
Dizzy Spells	Y ☐	N ☐	Sore Throat	Y ☐	N ☐
Sinus Problems	Y ☐	N ☐	Numbness/Tingling	Y ☐	N ☐
Excessive Thirst	Y ☐	N ☐	Urine Problems	Y ☐	N ☐
Too hot/cold	Y ☐	N ☐	Painful Urination	Y ☐	N ☐
Tired/Sluggish	Y ☐	N ☐	Bowel Problems	Y ☐	N ☐
Abdominal Pain	Y ☐	N ☐	Constipation	Y ☐	N ☐
Nausea	Y ☐	N ☐	Wheezing	Y ☐	N ☐
Vomiting	Y ☐	N ☐	Frequent Cough	Y ☐	N ☐
Indigestion	Y ☐	N ☐	Shortness of Breath	Y ☐	N ☐
Heartburn	Y ☐	N ☐	Swollen Glands	Y ☐	N ☐
Appetite, Normal	Y ☐	N ☐			

FOR WOMEN:

Pregnancies # _____ Children # _____

Other: _____

Age at first menses: _____ Date of last menses _____ ☐ N/A

Birth Control Pills ☐ N ☐ Y How long? _____

Hormone Replacement ☐ N ☐ Y How long? _____

Therapy _____ Date of Therapy _____

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