Ellis MEDICINE | ROSWELL PARK CARE NETWORK MEMBER
MEDICAL ONCOLOGY
1101 Nott Street, B6, Schenectady, NY 12308
P: 518.243.4762 | F: 518.243.4074

PLEASE ANSWER ALL THE QUESTIONS ON THE FOLLOWING FORMS AND BRING THEM TO YOUR DOCTORS VISIT.

Patient Information

Name: ______________________ Date of Birth: ____________
Address: ______________________
City: ______________________ State: __________ Zip Code: ________
Email: ______________________
Home Phone: ______________________ Cell Phone: ______________________

Advance Directives: (please check if you have any of the following)
☐ Health Care Proxy ☐ Living Will ☐ Durable Power of Attorney ☐ None
If None, would you like a copy? ☐ Yes ☐ Not at this time

Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other: ____________

Employment Information:
☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Other: ____________
Occupation: ______________________
If Employed Currently:
Name of Employer: ______________________
Phone Number: ______________________Ext.: ____________
Address: ______________________
City: ______________________ State: __________ Zip Code: ________

Insurance Subscriber Information: (if you are not the subscriber)
Subscriber Name: ______________________ Date of Birth: ____________
Address (if different from your own): ______________________
City: ______________________ State: __________ Zip Code: ________
Home Phone: ______________________ Relationship to you: ____________

Emergency Contact:

Name: ______________________ Relationship to you: ____________
Address (if different from your own): ______________________
City: ______________________ State: __________ Zip Code: ________
Home Phone: ______________________ Cell Phone: ______________________

Primary Care Physician / Provider: ______________________
Referring Physician/Provider: ______________________
Specialty Care Physician/Providers: ______________________

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Name: ______________________ DOB: ____________

Medication List: (attach separate sheet if needed)

Include all prescription, non-prescription, vitamins, herbal supplements, home remedies, birth control pills, hormone replacement therapies, etc.

Medication	Dose	Frequency

Medication, Food or Environmental Allergies:

Medication/Food/Environmental Allergen	Reaction

Surgical/Procedural History: (please list all surgeries or procedures and dates)

Implanted port placement: ______________________ Date: ______________________

Surgery/Procedure: ______________________ Date: ______________________

Surgery/Procedure: ______________________ Date: ______________________

Surgery/Procedure: ______________________ Date: ______________________

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Name: ______________________________ DOB: ______________

Personal Medical History: (please check all that apply and include date of diagnosis)

	Diagnosis	Date		Diagnosis	Date
	Anemia			High Blood Pressure	
	Anxiety / Depression			High Cholesterol	
	Arthritis			Kidney Disease	
	Asthma			Liver Disease	
	Bleeding Disorder			Mental Illness	
	Cancer (please list type)			Migraine Headaches	
	1.			Pneumonia	
	2.			Sexually Transmitted Disease	
	3.			Sleep Apnea	
	Diabetes			Stroke	
	Emphysema / COPD			Thyroid Disease	
	Epilepsy			Tuberculosis	
	Exposure to Asbestos			Ulcer	
	Heart Disease			Other:	
	Hepatitis *Type:* __________			Other:	

Social History:

Use of Alcohol ☐ No ☐ Yes Number of Drinks per Week: ____________________

Use of Tobacco ☐ No ☐ Yes ☐ Quit (date: __________) ☐ Packs per day: ________

Use of Drugs ☐ No ☐ Yes Type: ______________________________________

Caffeine Use ☐ No ☐ Yes Type: ______________________________________

Sexuality:

Sexually Active: ☐ No ☐ Yes ☐ Not at this time ☐ Prefer not to answer

(If applicable) Current Sexual Partner: ☐ Male ☐ Female

(If applicable) Do you practice Safe Sex: ☐ No ☐ Yes ☐ Prefer not to answer

Health Maintenance / Preventative Care

Colonoscopy	Date:	Mammogram	Date:	Bone Density:	Date:
☐		☐		☐	

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Name: ______________________ DOB: ______________

Gynecological History: (complete if applicable)

Number of Pregnancies: ____________ Number of Deliveries: ____________

1st day of most recent menstrual cycle: ______________ ☐ not applicable

☐ Menopause (date: __________)

☐ Age of 1st Menstrual Cycle: ________

Frequency of Cycle: ____________ Duration of Cycle: ____________

Do you have any concerns regarding your menstrual cycle: ☐ No ☐ Yes

If yes: ____

Immunization History: (please check any previous immunizations and include date)

Immunization	Date
☐ Chicken Pox	
☐ COVID-19	
☐ Smallpox	
☐ Tetanus	
☐ Hepatitis B	
☐ Influenza	
☐ Hemophilus (HIB)	

Immunization	Date
☐ Tuberculosis (PPD)	
☐ Polio	
☐ Measles	
☐ Pneumococcal	
☐ Other: ____________	
☐ Other: ____________	
☐ Other: ____________	

Family History:

Please list all family members with a history of cancer, pre-cancerous cells, or polyps.

Include: Parents, Siblings, and Children, Grandparents, Aunts/Uncles, Nieces/Nephews, Grandchildren, Half siblings, Great grandparents, Great Aunts/Uncles, Half Aunt/Uncles, First Cousins, and Great Grandchildren.

Relationship to patient	Maternal	Paternal	Cancer Type	Pre-Cancerous Cells or Polyps	Age at Diagnosis
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			

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Name: ___________________________________ DOB: ________________

Constitutional:
_______ Fevers/Chills/Night sweats
_______Unexplained weight loss/gain

Breast:
______Pain/swelling/change in color
______Nipple retractions
______Discoloration
______Breast Lump
______Discharge

Ears/Nose/Throat/Mouth:
_____Difficulty Hearing
_____Ringing in ears
_____Problems with Teeth & Gums
_____Hay fever/ Allergies
_____Difficulty Swallowing

Respiratory:
_____Cough/wheeze
_____Difficulty breathing
_____Pain when you breathe
_____Coughing up blood

Gastrointestinal:
_____Nighttime urination
_____Abdominal Distention
_____Abdominal pain
_____Nausea/vomiting/diarrhea
_____Blood in stool
_____Jaundice

Genitourinary:
_____Discharge: Penis or Vagina
_____Sexual function problems
_____Leaking urine
_____Blood in urine
_____Pain on urination

Musculoskeletal:
_____Back pain/Bone pain
_____Muscle/Joint pain
_____Swollen joints

Eyes:
_______ Change in vision
_______Redness of eyes
_______Double vision

Skin:
______Mole Change
______Rash

Cardiovascular:
_____Leg Pain
_____Palpitations
_____Chest pain/discomfort
_____Edema

Neurological:
_____Memory loss
_____Numbness
_____Loss of coordination
_____Headache
_____Dizziness/Light headed

Psychiatric:
_____Anxiety/ stress
_____Problems with sleep
_____Depression

Blood/lymph:
_____Weight Loss
_____Easy bruising/bleeding
_____Pallor
_____Night sweats
_____Unexplained Lump
_____Fatigue
_____Frequent Infections