

The Blood and Cancer Clinic P.A.

2125 VALLEYGATE DRIVE, SUITE 101

FAYETTEVILLE, NC 28304

Telephone #(910)483-8586

Fax # (910) 483-9212

SPECIAL NOTES SECTION

Please take a few extra minutes to complete this form front and back. This information is needed in order to provide you with the best care possible. In addition to listing your current medication(s), please bring your medicines with you on your first visit.

Patient Name: _____
Last First Middle.

Who referred you to this office? _____

Reason for the referral? _____

Patient's age: _____ Marital Status: Single Married Divorced Widowed

Children? YES or NO If so, how many? _____

Who do you live with? _____

Nursing Home: _____ How long there? _____

Do you smoke? YES or NO If so, for how long? _____ How much? _____

Do you use tobacco products (chewing tobacco, snuff, etc.)? YES or NO

If so, please describe:

Do you drink alcohol? YES or NO. If yes, how much? _____ How often? _____

Do you use drugs? YES or NO. If yes, please describe: _____

Please list any and all surgeries that you have had done:

Type of surgery:

Date of surgery:

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Shirish D. Devasthali, M.D.
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Medical Oncology, Hematology and Internal Medicine

Please list any major illnesses such as Diabetes, Heart Disease, Kidney problems, etc.

Please list all medications you are currently taking, including non-prescription medicines such as vitamins and over the counter medication:

Please list all allergies, including allergies to medications:

Has any family member been diagnosed with cancer? YES or NO
If yes, which family member and what type of cancer? (Example: Mother- breast cancer)

Has any family member been diagnosed with a blood disease such as anemia, sickle cell, leukemia, etc.? YES or NO. If yes, which family member, and what type of blood disease?

Please indicate if you have any of the following symptoms:

Fatigue	_____	Vomiting	_____
Weight Loss	_____	Pain (Location)	_____
Fever	_____	Diarrhea	_____
Night Sweats	_____	Change in Taste	_____
Chills	_____	Constipation	_____
Headaches	_____	Urinary Problems	_____
Sinus Problems	_____	Blood in Stool	_____
Vision Changes	_____	Blood in Urine	_____
Cough	_____	Bleeding (location)	_____
Shortness of Breath	_____	Weakness	_____
Chest Pain	_____	Swelling	_____
Dizziness	_____	Rashes	_____
Loss of Appetite	_____	Bruises	_____
Nausea	_____	Depression	_____
Anxiety	_____	Sexual Problems	_____

Do you have any other health problems or health concerns?
