Columbus	Jasonway Cancer Center 810 Jasonway Ave. Columbus, Ohio 43214-4359		Dublin Cancer Center 6700 Perimeter Drive Dublin, Ohio 43016-8063			Appointment Date:			
Oncology & Hematology Serving Obio Since 1987	Phone: (614) 442-3130 Fax: (614) 442-3150	30	Westerville Cancer Center 300 Polaris Pkwy, Suite 330 Westerville, Ohio 43082-7813			Location: Provider:			
Name (Last, First, Middle)		Birth Date			Age	So	cial Security #		
Address		I		City		St	ate	Zip Code	
Cell Phone	Home Phone	Work	Phone		Email Addro	ess			
	ell phone 🔲 Work pho	-	Email addre ou cannot b			to setup j	oatient portal a	nd con	tact you
Sex at birth Gender Iden Image: Description Image: Description of the second secon	Single L	ital Status ife Partner Vidowed	Divo		Employmen Working [Disabled		Occupati (Current or pre		Religion

EMERGENCY CONTACTS List at least 2:

Name:	Relation:	Cell phone:	Address:
Name:	Relation:	Cell phone:	Address:

PROVIDER INFORMATION

	Referred	Referring Physician's First & Last Name:		Phone:	Primary Care D	octor's First & Last Name:
	Self-Referred					
Dentist's First & Last Name:		Other (Name and type):			Other (Name and type):	

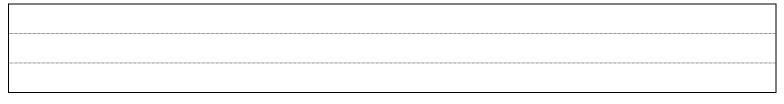
PHARMACY

Name, Address & Phone Number of preferred pharmacy:	Mail order pharmacy:

IMMUNIZATIONS

Pneumonia vaccine	Influenza (Flu Shot)	Shingles	Last COVID	RSV	Other
Date:	Date:	Date:	Date:	Date:	Date:

ALLERGIES List all allergies, describe your reaction:



REASON FOR REFERRAL Provide the history of your current problem (when it started; symptoms; treatment):

CURRENT MEDICATIONS Include prescription, <u>over-the-counter & herbals</u>. * Please attach an additional sheet or add to last page:

Name of Medication	Dose	How often taken	Reason for Medication	# of Years on Medication

MEDICAL HISTORY List all medical problems and past surgeries: (*ie. diabetes, hypertension, coronary artery disease, etc*)

CANCER HISTORY If you have a history of cancer, list the type of cancer and the treatment you've received:

Have you had genetic testing?
Yes No Any genetic changes?

FAMILY HISTORY List only cancer, blood, or genetic problems:

Relative Type	Father or Mother's side	Type of Cancer, Blood, or Genetic Problem	Age at Diagnosis

SOCIAL HISTORY

Tobacco	Have you ever smoked at least 100 cigarettes (5 packs) during your If you've quit, year did you quit: Number of packs you smoke(d) per day on average: Number of years you have smoked: Number of years you have smoked:					
	Tobacco products used:	Marijuana Vape Chewing tobacco/Dip Pipe Cigar				
	Do you drink alcoholic beverages regularly (at least 1 drink per month)?					
Alcohol	If Yes to the above, provide the following:	Total # of Drinks per Week: Maximum Drinks per Day: Type of Drink(s):				
Recreational	Have you ever used any recreational (street) drugs? 🗌 No 📄 Yes, currently 📄 Yes, but quit					
Drugs	If Yes to the above, which agents	have you used, and how much:				

SCREENING HISTORY

Type of Screening	Received	Date of Test	Results of Test	Due Next
Colonoscopy	Yes N	0		
Cologuard	Yes N	0		
Upper endoscopy (EGD)	Yes N	0		
Bone Density	Yes N	0		
Mammogram	Yes N	0		
PSA	Yes N	0		

To be answered by	Are you:	Pre-	menopausal	Perimenopau	sal OR	Post-me	enopausal		
WOMEN only	Are you current	tly preg	gnant?	Yes No	Are you plan	nning to bec	come pregnant?	Yes	No
When was your last ment	When was your last mentrual period?								
Oral Contraceptives (OCI	Ps)?		Yes	D No	If Yes, for	how long?			
Hormone Replacement Tl	nerapy (HRT)?		Yes	No No	If Yes, for	how long?			

GENERAL HEALTH QUESTIONS: Select all of the following you are you experiencing

*Attach additional sheets if needed

General	Gastrointestinal		Neurologic		Other	
Weight Loss	Abdor	ninal pain	Persistent headaches		Change in hearing	
Decrease in appetite	Consti	pation	☐ History of Stroke		Change in vision	
Fatigue	Diarrh	ea	Seizures		Diabetes	
☐ Night sweats	Nause	a	Numbness or tingling	g in hands	Rash	
Fever	Blood	in stool	or feet	g in nanos	☐ Kidney Disease	
Pain: Chronic or new						
If yes, please explain:	If yes, please explain:		If yes, please explain:		If yes, please explain:	
	n yes, preuse explain.		Jan, Panala Panala		5, <u>r</u>	
Heart/Lung		Blo	ood		Mental Health	
Shortness of breath		Bleeding after surger	У	Difficul	ty sleeping	
		Easy bruising/ bleedi	ng Anxiety			
Chest pain		Lymph node or gland			ssion symptoms	
Lower leg swelling	History of blood trans		sfusions 🗌 🖾 Memory		y loss	
If yes, please explain:	If yes, please explain:		If yes, plea		se explain:	

ADDITIONAL INFORMATION Use this space to note any additional comments, information, issues you would like us to know: