Your preferred pharmacy Name:_____

Phone Number:_____

LAKE ORION ROCHESTER
ONCOLOGY
drsobilo.com

Today's Date:_____

Your Name:_____ DATE OF BIRTH:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____ HOME PHONE:_____

CELL PHONE:_____ SEX:____ S.S.#_____EMPLOYER:_____

Your Spouse/Guardian:_____

IN CASE OF AN EMERGENCY WHOM MAY WE CONTACT?

NAME:_____ HOME PHONE:_____ CELL PHONE:_____

YOUR **PRIMARY** CARE PHYSICIAN:_____

YOUR **REFERRING** PHYSICIAN:_____

OTHER PHYSICIANS TO SEND INFO TO:_____

YOUR MEDICAL HISTORY: List your conditions:
USE EXTRA SHEET OF PAPER IF NEEDED

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____
11. _____ 12. _____
13. _____ 14. _____
15. _____ 16. _____

FAMILY MEMBERS MEDICAL HISTORY / GENETIC CONDITIONS

- ☐ Heart Attack_____
- ☐ Stroke_____
- ☐ Diabetes_____
- ☐ Epilepsy_____
- ☐ Lung Disease_____
- ☐ Arthritis_____
- ☐ Glaucoma_____
- ☐ Hypertension_____

Cancer in your family:
1. _____
2. _____
3. _____
4. _____

Allergies in your family
1. _____
2. _____
3. _____
4. _____

Please list any medications *YOU ARE ALLERGIC* to:

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

YOUR SYMPTOMS REVIEW (acute & chronic); DESCRIBE WHEN APPEARED / OCCURRED
Check all that apply

☐ Hearing problem	☐ Sputum	☐ Diarrhea	☐ Flank pain
☐ Ear infections	☐ Insomnia	☐ Constipation	☐ Sudden weight loss
☐ Double vision	☐ Memory loss	☐ Hemmrhoids	☐ Fatigue
☐ Eye pain	☐ Migranes	☐ Bloody stools	☐ Anemia
☐ Nose bleeds	☐ Dizzy spells	☐ Tarry stools	☐ Any pain
☐ Sinus troubles	☐ Palpitations	☐ Nervousness	☐ Increased thirst
☐ Headaches	☐ Swollen ankles	☐ Depression	☐ Stroke
☐ Hoarseness	☐ Calf pain	☐ Do you see a psychiatrist?	☐ Convulsions
☐ Difficulties swallowing	☐ Fainting spells	☐ Stomach ulcers	☐ Joint pain
☐ Cough	☐ Chest pain or tightness	☐ Blood in urine	☐ Back pain
☐ Short of breath	☐ Loss of appetite	☐ Frequent/difficult urination	☐ Numbness/tingling (where)
☐ Coughing blood	☐ Indigestion	☐ Abdominal pain	☐ Weakness right / left
☐ Wheezing	☐ Stomach ulcers	☐ Right upper quadrant pain	

WOMEN_____

Age with first period:_____ Date of last period:_____ Flows: Heavy Moderate Light

Days of flow (ie., number of days between first & last period 14, 28, 30, 32) _____

Do you have any pain or cramps during your menstrual cycle? _____

Number of pregnancies:_____ Number of live births:_____ Any miscarriges ?:_____

Age at delivery of 1st child:_____ Were you a nursing mother?:_____

Birth control method: birth control pills – IUD – tubal ligation – partner vasectomy – condoms –abstinence – other

PERSONAL HABITS please check one in each line

Alcohol use:	Avg. # per day _____	Avg. # per week _____	Avg. # per month:___
Smoking:	Avg. # per day _____	Avg. # per week _____	Avg. # per month:___
Exercise:	Avg. # per day _____	Avg. # per week _____	Avg. # per month:___

HOSPITILIZATIONS for ILLNESS or OPERATIONS / WHEN

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IMMUNIZATIONS _____

If you received any of the following injections, please mark the appropriate box and indicate the date if known

☐ Small pox	☐ Mumps	☐ Pertussis	☐ Typhoid
☐ Rubella	☐ Polio	☐ Measles	☐ Diptheria
☐ Tetanus	☐ Flu	☐ HIB	☐ Varicella

COMMENTS OR QUESTIONS_____

_____