Dr. Mohtaseb Cancer Center and Blood Disoder (HOANJ, LLC)
Hamdy Mohtaseb MD, FACP

MY HISTORY

Name:_____ Date of birth: _____

Primary care provider name: _____

Referring provider name: _____

Reason for referral: _____

Chief complaint (primary reason for today's visit):

_____

_____

_____

MY MEDICAL PROFILE

MEDICAL CONDITIONS: (For example: high blood pressure, heart trouble, diabetes, depression, breathing problems, other)

Condition	Year Diagnosed	How Is it Treated

SURGERIES

Type of Surgery	Date	Hospital	Reason for Surgery

MY HISTORY

Name:_____ Date of birth: _____

SOCIAL HISTORY

Tobacco Use

Please check one

_ I have never smoked

_ I have smoked, but rarely

When was the last time?_____

_ I have quit smoking. Quit Date:_____

How many packs/day?_____ How many yrs?_____

_ I currently smoke _____pack(s)/day.

How many yrs._____

Other Tobacco: _ pipe _ cigar _ snuff _ chew

Are you interested in quitting? _ Y _ N

Alcohol Use

Do you drink alcohol? _ Y _ N

_ never _ occasionally _ regularly

Average # drinks/week? 5 oz. wine_____

12 oz. beer_____ 1.5 oz. hard liquor_____

Is alcohol use a concern for you or others? _ Y _ N

Drug Use

Do you use recreational drugs? _ Y _ N

Type of drug:_____

Have you ever used needles? _ Y _ N

Marital Status: _ single _ married _ separated _ divorced _ widow

Children: _ Y _ N If yes, how many: _____

Current occupation: _____

Secondary occupation: _____

_ Retired _ Full time student _ Disabled _ Never

Former occupation: _____

Occupational exposure (asbestos, benzenes, other chemicals, etc):

_____

MY HISTORY

Name:_____ Date of birth: _____

FAMILY HISTORY

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Alive?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	
Anemia							
Bleeding disorders							
Blood count disorders							
Breast cancer							
Cancer							
Clotting disorder							
Colon cancer							
Diabetes							
Heart disease							
Hypertension							
Kidney disease							
Leukemia							
Lung cancer							
Lymphoma							
Melanoma							
Multiple myeloma							
Ovarian cancer							
Sarcoma							
Other (specify)							

MEDICATION I TAKE:

Information the doctor will want to know for each medication:

Why are you taking it?

How long have you been taking it?

What is the dosage?

How many times a day do you take the medication? (If you are not sure, bring the medication with you.)

Medication	Dose	Number of Times Taken Per Day	Date Started	Prescribed By

MY HISTORY

Name:_____ Date of birth: _____

OTHER MEDICATION I TAKE:

Remember to include on your list any over the counter (OTC) medicine you take (vitamins, herbs, pain relievers, supplements, etc.).

Other Medication	Dose	Number of Times Taken Per Day	Date Started

MY CANCER DIAGNOSIS

Date of Surgery or Biopsy	
Doctor	
Place Procedure Was Performed	
Surgery That Was Performed	
Results of My Surgery	
Primary Cancer Type	
Type of Tumor (Histological Type)	
Stage of Disease	
Any Problems Since My Surgery	

MY HISTORY

Name:_____ Date of birth: _____

ALLERGIES: (For example: medications, food, and/or other substances)

Allergy	Allergic Reaction (What symptoms develop?)

Any additional information you would like to share with your doctor:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The questions on this form have been answered to the best of my ability.

_____

Patient Signature: Date: