Lowcountry Hematology and Oncology
Roper St. Francis Physicians

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MATTHEW A. BELDNER, MD
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RYAN A. KALINSKY, MD
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PATIENT HISTORY FORM

Biographical Information

Today's Date: ______/______/______

Last Name ________________ First Name _____________ Middle _________ Acct# _______________

Date of Birth _______________

Chief Complaint (What is the reason for your visit today?)

History of Present Illness

1. What is the problem?
2. When did you first notice it?
3. How and where was it first diagnosed? Please give the names of any physicians involved.
4. Does it interfere with your normal daily functioning? How?

Past Medical History

1. Please list any other illnesses that you have.
2. Please list your medications, including over the counter types. Please include the dose and how often you take them.
3. Are you allergic to any medications? Please describe the reaction when you take it.
4. Do you smoke? If so, how much and when did you start?
5. Does cancer or blood disease run in the family? Please give details (who and what kind).
6. Have you had surgery before? Please list the name of the procedure, date and place.

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REVIEW OF SYSTEMS

Today's Date: ______/______/______

Patient Name: ________________________________ DOB: ____________________ Acct# _________________

Please check any problems that may apply.

General Symptoms		
• Fever	Y	N
• Chills or Night Sweats	Y	N
• Weight Loss	Y	N
• Other:		

Skin		
• Rashes	Y	N
• Lesions	Y	N
• Itching	Y	N
• Other:		

Head and Eyes		
• Headache	Y	N
• Blurry vision	Y	N
• Double vision	Y	N
• Other:		

Blood/Lymphatic		
• Easy bruising	Y	N
• Bleeding	Y	N
• Swollen glands	Y	N
• Other:		

Ear/Nose/Throat		
• Hearing Loss	Y	N
• Runny Nose	Y	N
• Sore Throat//Tooth Pain	Y	N
• Other:		

Neurologic		
• Seizures	Y	N
• Dizzy/Loss of consciousness	Y	N
• Numbness/Tingling	Y	N
• Other:		

Respiratory		
• Shortness of Breath	Y	N
• Cough	Y	N
• Wheezing	Y	N
• Other:		

Psychologic		
• Depression	Y	N
• Anxiety	Y	N
• Thoughts of Suicide	Y	N
• Other:		

Cardiovascular		
• Chest pain	Y	N
• Palpitations/Racing heart	Y	N
• Swollen ankles	Y	N
• Other:		

Musculoskeletal		
• Joint pain	Y	N
• Bone pain	Y	N
• Lower back or neck pain	Y	N
• Other:		

Gastrointestinal		
• Abdominal pain	Y	N
• Nausea/vomiting	Y	N
• Diarrhea/constipation	Y	N
• Other:		

Endocrine		
• Too hot or cold	Y	N
• Excessive thirst	Y	N
• Frequent urination	Y	N
• Other:		

Genitourinary		
• Pain when urinating	Y	N
• Blood in urine	Y	N
• Heavy menstrual bleeding	Y	N
• Other:		

Other (Please fill in)		
•	Y	N
•	Y	N
•	Y	N
•		

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Patient Name:_______________________________ **DOB**:____________________ **Acct#**_____________

These are the usual required questions for PET/CT scans and MRI's

MRI

Has the patient ever had an MRI? If so where?_______________________________________
Is the patient diabetic? If yes, how is it controlled?_____________________________________
Does the patient have a history of kidney disease?
Is the patient on dialysis?
Does the patient have a history of high blood pressure?
Is the patient claustrophobic?
Does the patient have a cardiac pacemaker, artificial heart valve, or brain aneurysm clip?
Does the patient have metal anywhere in their body? If yes, where?______________________
Has the patient had any recent surgeries or biopsies? If yes, when__________________________
Has the patient had a BUN and creatinine performed in the past 30 days?

CT

Is the patient diabetic? If yes, how is it controlled?_____________________________________
Does the patient have a LifePort?
Are both kidneys functioning?
Is the patient claustrophobic?
Is the patient allergic to iodine or contrast?
Has the patient had a BUN and creatinine performed in the past 30 days?

PET

Is the patient diabetic? If yes, how is it controlled?_____________________________________
Does the patient have a LifePort?
Last date of radiation?
Last date of chemotherapy?
Is the patient on any Neupogen or steroids?
Has the patient had any recent surgeries or biopsies?
Has the patient had a BUN and creatinine performed in the past 30 days?

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