

Glenn Tisman, M.D.
Hematology • Oncology

Medical Questionnaire:

Date: _____

Name _____
Last First Middle

Gender: Male Female Age: _____

Date of Birth: _____ Birth Place: _____

Social Security Number: _____ - _____ - _____ Driver's License #: _____

Mother's Maiden Name: _____

Language Spoken: _____

Home Address: _____

City: _____ State: _____ Zip code: _____ - _____

Phone: _____ Fax: _____ E-mail: _____

Marital Status: Single Married Widowed
 Divorced Separated

Spouse's Name: _____ Years Married: _____

Spouse's Date of Birth: _____

Employer: _____ Occupation: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip-code: _____ - _____ Fax: _____

(Not living in the same household)

Name of Emergency Contact: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip-code _____ - _____

Phone: _____ Fax: _____

Local Telephone Number for Out-of-Town Patients: (Relative, Friend, or Hotel)

Name of Contact: _____ Phone: _____

1. Referring Physician: _____
Specialty: _____
Address: _____
City: _____ State: _____ Zip-code: _____ - _____
Phone: _____ Fax: _____

1. Other Physician: _____
Specialty: _____
Address: _____
City: _____ State: _____ Zip-code: _____ - _____
Phone: _____ Fax: _____

2. Other Physician: _____
Specialty: _____
Address: _____
City: _____ State: _____ Zip-code: _____ - _____
Phone: _____ Fax: _____

Periodic reports may be sent to your physician(s).
To whom would you like them sent? [Circle number(s)]

1. 2. 3.

Have you or family members had a previous history of anesthesia problems? (Explain)

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Patient Name: _____

Billing Information:

Self Pay

Insurance

Other

Employer Offered Plan? Yes / No (Circle one)

Insurance Company (Primary) _____

Policy #: _____ Group #: _____

Guarantor: _____ Guarantor's Date of Birth: _____

Relationship to Patient: _____ Social Security #: _____

Address if different from patient: _____

Employer Offered Plan? Yes / No (Circle one)

Insurance Company (Secondary) _____

Policy #: _____ Group #: _____

Guarantor: _____ Guarantor's Date of Birth: _____

Relationship to patient: _____ Social Security #: _____

Address if different from patient: _____

* **NOTE:** Please present your medical insurance card(s) at the front desk.

All professional services are the responsibility of the patient. Necessary forms are completed to expedite insurance carrier payments, however, the patient is responsible for all fees, regardless of insurance coverage. Payment for services is due on date of service unless other arrangements are made in advance with our office bookkeeper.

Insurance Authorization and Assignment

Name of Policyholder _____ **Insurance ID #:** _____

I request that payment of authorized insurance company benefits be made either to me or to Glenn Tisman, MD, A Medical Corporation, on my behalf, for any services furnished to me by the party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of my personal medical or other information to release any information needed for this or a related Medicare/other insurance company claim to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider or any other party who might be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Signature: _____ **Date:** _____

YOUR MEDICAL HISTORY

Help us understand your medical history by providing accurate information below.

Past Surgeries (Operations):

Please list in chronological order

DATE	TYPE OF OPERATION	REASON FOR SURGERY	HOSPITAL	DOCTOR

Past Medical Illnesses (Such as heart disease, diabetes, T.B., cancer, etc.):

Please list in chronological order

DATE	TYPE OF ILLNESS	DOCTOR

Other Hospitalizations:

Please list in chronological order

DATE	REASON	HOSPITAL	DOCTOR

Radiation Therapy Treatment:

(Please list in chronological order. We need to know when treatment started and when it was completed)

STARTED:		STOPPED:		Area of Body Treated	Hospital	Doctor
Month	Year	Month	Year			

MEDICATIONS

This is an important section, and should you visit our office frequently, you will be asked each time for an updated medication list. Please list any medications you are now taking, **INCLUDING** over the counter or non-prescription drugs (i.e. aspirin, Tylenol, vitamins, diet pills, pain pills, tranquilizers, sleeping pills, etc.)

Indicate DOSAGE and FREQUENCY for each medication.

1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

ALLERGIES:

Please list any medication to which you have had an allergy.

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Iodine
<input type="checkbox"/> X-Ray Contrast (Dye)	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Explain the nature of the allergic reaction (i.e. rash, difficulty breathing, etc.):

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Patient Name: _____

Please indicate if you have a **PAST** history of these problems, or if you are **PRESENTLY** experiencing them. If you are not sure, please mark "Do not know" and we will assist you during your visit. When there are several possible choices, please **CIRCLE** the appropriate answer.

GENERAL

Condition	YES		NO	Do Not Know
	Past	Present		
1. Swollen or enlarged (lymph) glands				
2. Diabetes				
3. Other tumors or cancer:_____				
4. Mumps				
5. Rheumatic fever				
6. Scarlet fever				
7. Nervous disorder:_____				
8. Gallbladder disease				
9. Venereal disease				
10. Hepatitis				
11. Cirrhosis				
12. Epilepsy				
13. Unusual Fatigue				
14. Skin rash / discoloration / Sensitivity (circle one)				

HEAD, EYES, EARS, NOSE, THROAT - (HEENT)

Condition	YES		NO	Do Not Know
	Past	Present		
1. Headaches				
2. Dizziness OR fainting (circle one)				
3. Eye injuries: Right / Left / Both				
4. Double vision: Right / Left / Both				
5. Blurred vision: Right / Left / Both				
6. Eye pain : Right / Left / Both				
7. Cataracts: Right / Left / Both				
8. Glaucoma: Right / Left / Both				
9. Earaches				
10. Ringing OR buzzing in ear (circle one)				
11. Hearing decrease OR loss (circle one)				
12. Spinning sensation				
13. Sinus trouble				
14. Nose bleeding				
15. Sore tongue				

HEAD, EYES, EARS, NOSE, THROAT - (HEENT) Continued

16. Bleeding gums				
17. Unusual trouble with teeth				
18. Skin disease:-----				
19. Skin tumors OR moles (circle one) removed or burned (circle one)				
20. Chronic or frequent infections, colds				

ENDOCRINE

Condition	YES		NO	Do Not Know
	Past	Present		
1. Thyroid: Hyper OR Hypo (circle one)				
2. I take thyroid medication.				
3. Goiter				
4. Frequent laryngitis				
5. Hoarseness OR change in voice				

BREAST

Condition	YES		NO	Do Not Know
	Past	Present		
1. Lumps in breast: (circle one) Right / Left / Both				
2. Pain in breast: (circle one) Right / Left / Both				
3. Nipple discharge: (circle one) Right / Left / Both				

HEART

Condition	YES		NO	Do Not Know
	Past	Present		
1. Heart disease: -----				
2. Bleeding tendency OR easy bleeding (circle one)				
3. High blood pressure				
4. Pain OR pressure in chest (circle one)				
5. Ankle swelling: Right / Left / Both				
6. Pain in legs while walking				
7. Irregular heart beat OR Palpitations (within past 6 months)				
8. Heart murmurs				

PULMONARY

Condition	YES		NO	Do Not Know
	Past	Present		
1. Chronic cough				
2. Coughing up blood				
3. Undue shortness of breath: At rest OR With exercise OR Both				
4. I have a history of Chronic Obstructive Pulmonary Disease (COPD).				
4. Do you have the date of your last chest x-ray? Date: _____				
5. Soaking sweats				
6. Exposure to TB				
7. Asthma OR allergies (circle one)				

GASTROINTESTINAL

Condition	YES		NO	Do Not Know
	Past	Present		
1. Stomach / liver / intestinal trouble (circle one)				
2. Recent weight gain or loss (lbs.): Gain: Loss:				
3. Decreased appetite				
4. Difficulty swallowing				
5. Nausea				
6. Vomiting				
7. Frequent bowel movements				
8. Constipation				
9. Change in bowel movements: Describe:_____				
10. Black bowel movements				
11. Blood in stools				
12. Jaundice				

GENITOURINARY

Condition	YES		NO	Do Not Know
	Past	Present		
1. Kidney trouble Describe:_____				
2. Frequent urination				
3. Painful urination				
4. Kidney stones				
5. Blood in urine				
6. Sugar or albumin in urine				
7. Slow starting of urine stream				
8. Passing urine at night: Frequency:_____				

MUSCULOSKELETAL

Condition	YES		NO	Do Not Know
	Past	Present		
1. Arthritis (RO or OA)				
2. Rheumatism				
3. Back pain: Upper / Lower / Mid (circle one)				
4. Joint swelling				
5. Bone pain				
6. Clumsiness / awkwardness of hands				
7. Clumsiness / awkwardness of feet				
8. Numbness OR tingling (circle one) in hands OR feet (circle one)				
9. Muscle pain				
10. Weakness				

NEUROLOGIC

Condition	YES		NO	Do Not Know
	Past	Present		
1. Forgetfulness				
2. Reactions to serum or drugs Type of serum or drug:_____				
3. Excessive worry				
4. Excessive depression				
5. Nervous disorder: Describe:_____				
6. Sexual impotence				
7. Seizures				
8. Strokes				
9. Trans Ischemic Attack (TIA)				

HABITS

Condition	YES		NO	Do Not Know
	Past	Present		
1. Alcohol intake: Indicate the type of drink, amount, and frequency (i.e. daily, weekly or monthly). 1. 2. 3.				
2. I have a history of substance abuse.				
3. I have a history of smoking tobacco/other.				
4. If you currently or ever smoked regularly, please answer: How many years?_____				
How frequently?_____				
When stopped?_____				

WOMEN ONLY

GYNECOLOGICAL

Condition	YES		NO	Do Not Know
	Past	Present		
1. Vaginal bleeding after intercourse				
2. Painful menstruation				
3. Irregular menstruation				
4. Excessive menstruation				
5. Vaginal discharge				
6. I was treated for female disorder: Describe:_____				
7. I have used an Intrauterine Device (IUD)?				
8. Have you gone through Menopause? If yes, age:_____				

Please list any past breast problems:

Have you ever taken hormones? ___YES ___NO

If yes, indicate type: _____

Duration: _____

When stopped? _____

Have you ever taken birth control pills? ___YES ___NO

If yes, indicate type: _____

Duration: _____

When stopped? _____

Age at onset of menstruation: _____

Interval between periods: _____

Number of pregnancies: _____

Number of births: _____

Number of abortions: _____

Your age at birth of your first child: _____

Family history of breast problem: _____

Date of your Last Menstrual Cycle (LMC): _____

FAMILY HISTORY

If any family member has cancer or had a history of cancer, please specify the type of cancer, if possible):

RELATION	AGE	STATE OF HEALTH	IF DECEASED- CAUSE OF DEATH	AGE AT DEATH
Father				
Mother				
Spouse				
Brothers				
Sisters				
Children				

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Patient Name: _____

Have any of your blood relatives, husband, wife or children had any of the following?

(CHECK EACH ITEM)	YES	NO	RELATION (S)
Tuberculosis			
Diabetes			
Cancer			
Leukemia			
Anemia			
Bleeding tendency			
Heart disease			
High blood pressure			
Kidney disease			
Asthma, hay fever, other allergies (circle all that apply)			
Chronic arthritis (Rheumatism)			
Nervous or mental disorder			
Goiter			
Emphysema			
Any other illness			

Patient Name: _____