

HEMATOLOGY ONCOLOGY LIFE CENTER, L.L.C.
605 B Medical Center Drive • P.O. Box 8255
Alexandria, LA 71306-1255

PERSONAL HISTORY

(To Be Completed by the Patient)

DATE _____

Please use ink or typewriter, do not use pencil

NAME _____

Address _____

Age _____ Sex _____ Occupation _____ Descent (Race or Nationality) _____

Were you referred by a physician for this visit? _____

Name and full address of your physician _____

Do you wish a medical report sent to your physician? _____

Please state briefly the main problem which prompted you to consult us, and the length of time you have had it.
 (If a checkup, so state)

I. PAST MEDICAL HISTORY:

Have You Had:

	No	Yes	Year		No	Yes	Year		No	Yes	Year
Tuberculosis <small>or a Positive TB Skin Test</small>				Kidney or Bladder Infection				Peptic Ulcer			
Pneumonia or Pleurisy				Kidney Stones				Ulcerative Colitis			
Cancer				Arthritis or Joint Trouble				Liver Disease			
Epilepsy				Ruptured Disc or Sciatica				Jaundice or Hepatitis			
Stroke or Paralysis				Gout				Gallbladder Disease			
Heart Disease or Murmur				Asthma				Rectal or Colon Polyps			
High Blood Pressure				Hay Fever				Hemorrhoids			
Blood Disease or Anemia				Hives				Diabetes			
Bleeding Tendency				Skin Disorder				Goiter or Thyroid Trouble			
Kidney Disease				Chronic Lung Disease				Other Glandular Trouble			

Any illness or disease not included in above _____

