



# Halifax Health - Center for Oncology

**At Halifax Medical Center**    **In Ormond Beach**    **In New Smyrna Beach**    **In Port Orange**  
303 N. Clyde Morris Blvd.    1688 W. Granada Blvd.    401 Palmetto St.    1185 Dunlawton Ave.,  
Daytona Beach, FL    Ormond Beach, FL    New Smyrna Beach, FL    Suite 105  
Port Orange, FL  
**(386) 254-4212**    **(386) 615-4400**    **(386) 424-5038**    **(386) 322-4750**

Patient name \_\_\_\_\_  
Adm. date \_\_\_\_\_ Dr. \_\_\_\_\_  
Date of birth \_\_\_\_\_  
Med. rec. # \_\_\_\_\_ Visit # \_\_\_\_\_

## MEDICAL HISTORY AND MEDICATION SUMMARY (CONTINUED)

Your Cell Phone Number (Optional): \_\_\_\_\_

### Emergency Contact Information

Name: \_\_\_\_\_  
Phone Number \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

### Pharmacy

Name: \_\_\_\_\_ Location: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

### Cancer Screening

Please give approximate date of the following cancer screenings

Last Colonoscopy \_\_\_\_\_ Last Chest X-ray \_\_\_\_\_  
Last PAP Smear (For females) \_\_\_\_\_ Last Mammogram (For females) \_\_\_\_\_  
Last PSA (For males) \_\_\_\_\_

### Allergies

Please list medication / food / vitamin supplement and what type of bad reactions

\_\_\_\_\_  
\_\_\_\_\_

### Medications

#### Prescription Medications, Over the Counter Medications, and Vitamin and Herbal Supplements

Name of Medication	Dose	How Often Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have signed Advanced Directives: Living Will?  Yes  No

Designation of Health Care Surrogate?  Yes  No

Durable Power of Attorney for Health Care?  Yes  No

If "yes" to the above, we would appreciate a copy for our records. If "no," would you like information?  Yes  No

Print Your Name: \_\_\_\_\_

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

