Maciej Drazkiewicz, M.D
Hematology and Oncology
Certified by the American Board of Internal Medicine

2222 W Division St
Suite 215
Chicago, IL 60622
(773) 227-8807

1022 N Northwest Hwy
Park Ridge, IL 60068
(773) 227- 8807

3929 N Central Ave.
Suite 1
Chicago, IL 60634
(773) 227-8807

Name:_____Date:_____
DOB:_____Allergies:_____
Referring physician:_____
Primary care physician: _____

VACCINATION

Vaccine	No	Yes	When and where
Influenza			
Pneumococcal			

SOCIAL HISTORY

Tobacco	Never	Current-how many packs/cigs daily? How many years?	Past use date? How many years? How many packs/cigs daily?
Cigarettes			
Cigars			
Chewing tobacco			

Alcohol	Never	Current-How many drinks daily/weekly/monthly? How long?	Past use-Quit date? How many years of use? How often daily/weekly/monthly?
Beer			
Wine			
Liquor			

Illicit drug use	Never	Current-How often daily/weekly/monthly? How long?	Past use-Quit date? How many years of use? How often daily/weekly/monthly?
Marijuana			
Cocaine			
Heroin			
Pain pills			
Other:			

SCREENING

	Never	Normal When?	Abnormal-When? Where? Result? Performing MD
Mammogram			
Colonoscopy			
PSA			
Bone density (DEXA)			
Pap smear/pelvic exam			

MEDICAL AND FAMILY HISTORY

Healthy □ Old Age □

Have you or a member of your family been diagnosed with:

	You	Family-Who?		You	Family-Who?
Alcoholism			Allergies/hay fever		
Alzheimer's			Anemia		
Aneurysm			Anxiety/depression/dementia		
Arrhythmia			Arthritis		
Asthma			Atrial fibrillation		
Benign breast cyst			Bipolar disorder		
Birth defects/mental retardation			Bleeding disorder/blood clots		
CAD/MI			Cardiac arrhythmia		
Cancer_____			Colon polyps		
Complements deficiency			Con. heart failure		
COPD/emphysema/bronchitis			CVD/stroke/TIA		
Diabetes:			Dialysis		
Eczema/skin disorders			Epilepsy/seizures		
Eye problems:			Familial polyposis of colon		
Glaucoma			Gun shot wound(GSW)		
Headaches/migraines			Hearing problems		
Heart attack			Heart disease		
Hepatitis			HIV		
High blood pressure (HTN)			High cholesterol/hyperlipidemia		
Immunosuppressive disorder			Intestinal/digestive problems		
ITP			Juvenile rheumatoid arthritis(JRA)		
Kidney disease			Leukemia_____		
Liver disease			Lupus		
Lymphoma			Macular Degeneration		
Melanoma			Multiple sclerosis		
Muscular problems			Obesity		
OCD			Osteoporosis		
Parkinson's disease			Pelvis fracture		
Peripheral vasc. disease			Pneumonia		
Pulmonary embolism			Prostate problems		
Renal failure			Rheumatoid arthritis		
Sarcoidosis			Sepsis		
Sickle cell disease/trait			Substance abuse		
Suicide			STD		
Thyroid problems/hyperthyroidism			Tuberculosis		
Ulcers/gastritis			Uterine fibroids		
Varicose veins			Other blood problems		
Other heart problems			Other infectious disease		
Other psych. Diag.					

Have you recently had any of the following symptoms?

	Yes	How long?		Yes	How long?
Fever/chills			Change in bowel habits		
Nose bleeds			Blood in stools		
Weight change			Easy bruising/bleeding		
Fatigue			Nausea/Vomiting		
Loss of appetite			Skin changes/itching		

Swelling-where?			Difficulty/pain urinating		
Pain-location?			Abnormal discharge		
Cough			Memory loss		
Shortness of breath			Headaches		
Sores or ulcerations			Lumps or nodules		
Dizziness/fainting			Mental changes		
Weakness in extremities			Other:		
Numbness or tingling					

Have you had any surgeries or hospitalizations? Please include year if known:_____
_____
_____
_____

Have you received chemotherapy before? _____

GYNECOLOGICAL HISTORY

Age of first menstruation?____ Frequency? _____ Duration? _____
Abnormalities? (pain, heavy, clotting, irregular,etc)_____
How Many pregnancies? _____ How many children? _____ Age of first pregnancy?_____
History of contraceptive use □ yes □ no What kind?_____ How long? _____
Age of menopause? _____ Hormone replacement therapy? How long?_____ What kind?_____
Ever had an abnormal pap smear? When and what treatment? _____
Current employment:_____ full time part time
Occupation:_____ Type of work:_____

Have you been exposed to occupational hazards such as: □ asbestos □ fumes □ solvents □ chemicals □ dust or airborne particles □ radiation □ other:_____

Marital Status:
□ Single □ Married □ Divorced □ Separated □ Widowed

Who lives at home with you?_____

Do you have a power of attorney or living will? □ yes □ no
Who?_____Relationship_____

Do you exercise?_____

Additional information:_____
_____
_____

HOME MEDICATION LIST

Medication name and dose	Frequency/time

PHARMACY INFORMATION:

Local pharmacy: _____
Address/location: _____
Phone number: _____Fax:_____

Mail-in pharmacy:_____Phone#_____

I attest that this information is true to the best of my knowledge:

Patient signature:_____Date:_____

Physician signature:_____Date:_____