HEMATOLOGY/ONCOLOGY PATIENT INITIAL HISTORY

Name: _____Age: _____Date: _____

Physician to who report is to be sent: _____

Why have you come to see the doctor?
_____
_____
_____
_____

Patient Surgical History: Please list all operations, and the dates of operations(s).

1.

2.

3.

4.

Special Tests: HIV status ☐Positive ☐Negative ☐Never Tested

☐Yes ☐ No Have you had genetic testing for risk of cancer or other

disorders? If yes, please explain_____
_____

☐Yes ☐No Have you had a sigmoidoscopy or colonoscopy? _____

Social History:

☐Yes ☐No Have you smoked?
If yes, how many packs/day_____How many years_____If you quit, when? _____

☐Yes ☐No Have you used smokeless tobacco?

If yes, for how many years_____If you quit, when? _____

☐Yes ☐No Have you drunk heavily?

If yes, how much, for how long and when did you stop? _____

How many drinks do you have in the average week? _____ _____ _____
Liquor Beer Wine

☐Yes ☐No Have you used illicit drug?

If yes, please explain: _____

Are you employed outside the home? ☐Yes ☐No ☐Retired ☐Disabled

If employed, retired, or disabled, what do/did you do? _____

Highest level of education that you've completed? _____

Marital status_____ If married, what's your spouse's occupation? _____

With whom do you live? _____

Is there anything else about you or your situation that we should know? _____

Patient Communication/Learner Assessment:

1. When learning new information about your health, do you have any difficulty because of the following?

_____ I cannot hear well
_____ I cannot see well
_____ I do not speak English well
_____ I cannot read English well
_____ I have trouble remembering
_____ No difficulties
_____ Other_____
_____

2. If there is someone needed to help you (e.g. act as an interpreter), please name that person: _____

3. Preferred instruction method: ☐Written ☐Oral ☐Demonstration

4. Do you have religious or cultural beliefs you want us to consider when we are planning your care? ☐Yes ☐No If yes, please explain _____
_____

Past Medical History: Please list all major illnesses that you have, or have had, the date of diagnosis and the treatment given (for example: high blood pressure, diabetes, heart disease, stroke). Also include major non-surgical hospitalization:

Illness	Date	Treatment

Allergies: Please list all drugs and substances to which you are allergic and the kind of allergic reaction (e.g. hives, breathing problems, rash).

_____

_____

_____

Women: Age period started: _____ Last normal menstrual period_____ Age when periods stopped: _____ Number of pregnancies: _____ Number of live births: _____
Number of miscarriages: _____ Age at first pregnancy: _____At first live birth_____ Number of children breast-fed: _____
Have you ever taken oral contraceptives? ☐ Yes ☐ No
If yes, year started: _____ Year Stopped: _____ Type: _____
Date of last mammogram: _____ Pap: _____
Have you ever taken a hormone replacement therapy? ☐Yes ☐No
If yes, year started: _____ Year stopped: _____ Type: _____

Men: Number of children fathered: _____
Last PSA: _____ Result: _____

Family History: List their age if living (L) or at death if not living (NL) and age at diagnosis of major illnesses. Continue on back of if you need more room:

Relationship	Age (L/NL)	Major Diseases (and age of onset)
Mother	_____	_____
Father	_____	_____
Sister	_____	_____
Sister	_____	_____
Brother	_____	_____
Brother	_____	_____
_____	_____	_____
_____	_____	_____

If your cousins, nieces, aunts, uncles, or grandparents had any cancer, please list the relationship to you and the cancer type.

_____

_____

_____

Toxin & Radiation Exposure:

Were you ever exposed to radiation, toxic chemicals, fumes, or extensive sun? ☐ Yes ☐ No

If yes, please list toxin, place and dates of exposure:

Toxin	Place/date of Exposure
_____	_____
_____	_____

Prescription medications taken regularly:

Start Date	Drug	Dose	How Often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Herbals, Supplements, Vitamins: _____
_____
_____

Travel History (country and dates): _____
_____
_____

Pets: Currently or recently owned: _____
_____

Please check signs or symptoms you are currently experiencing:

General:

☐ No problems experienced
☐ Tiredness: How much daytime do you spend in bed?
☐ Less than 25%
☐ 25-50%
☐ More than 50%

☐ Weakness
☐ Fevers
☐ Chills
☐ Weight Loss
☐ Night Sweats

Please check signs or symptoms you are currently experiencing:

Skin, Hair, Nails, Breast:

- ☐ No problems experienced
- ☐ Pale
- ☐ Jaundice (yellow skin)
- ☐ Ruddy facial complexion
- ☐ Itching
- ☐ Typical blotchy rash
- ☐ Easy bruising
- ☐ Spontaneous bruising
- ☐ Frequent skin infections
- ☐ Change in hair texture, color, or distribution
- ☐ Change in nail texture
- ☐ Breast pain
- ☐ Breast lumps
- ☐ Nipple discharge

Eyes:

- ☐ No problems experienced
- ☐ Blind
- ☐ Recent change of eyeglass prescription
- ☐ Blurry vision
- ☐ Double vision
- ☐ Blind spots
- ☐ See rainbow, light flashes, or floaters
- ☐ Eye pain

Ears:

- ☐ No problems experienced
- ☐ Deafness
- ☐ Difficulty hearing
- ☐ Earache/ear pain
- ☐ Ringing in ears
- ☐ Discharge from ears

Nose:

- ☐ No problems experienced
- ☐ Stuffiness
- ☐ Discharge
- ☐ Sneezing
- ☐ Bleeding
- ☐ Frequent colds
- ☐ Sinus pain

Throat:

- ☐ No problems experienced
- ☐ Sore throat
- ☐ Change in voice
- ☐ Hoarseness
- ☐ Lump in throat

Respiratory:

- ☐ No problems experienced
- ☐ Cough
- ☐ Sputum production
- ☐ Blood in sputum
- ☐ Shortness of breath at rest
- ☐ Shortness of breath on exertion
- ☐ Wheezing
- ☐ Sharp or stabbing chest pain that is worse when inhale

Please check signs or symptoms you are currently experiencing:

Cardiac:

- ☐ No problems experienced
- ☐ Palpitations
- ☐ Pressure sensation in your chest
- ☐ Chest pains at rest
- ☐ Chest pains at exertion
- ☐ Shortness of breath when lying down
- ☐ Need to sleep propped on pillows
- ☐ History of heart murmur
- ☐ Swelling of your arms
- ☐ Swelling of your legs
- ☐ Pain in your calf muscles at rest
- ☐ Pain in your calf muscles when you walk
- ☐ Varicose veins

Gastrointestinal:

- ☐ No problems experienced
- ☐ Change in eating habits or diet
- ☐ Indigestion
- ☐ Abdominal distention
- ☐ Abdominal pain or cramps
- ☐ Gaseousness
- ☐ Fatty food intolerance
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in stool, alteration in stool caliber
- ☐ Hemorrhoids
- ☐ Hernia

GU & VD:

- ☐ No problems experienced
- ☐ Trouble holding your urine
- ☐ Pain upon urination
- ☐ Get up more than once during the night to empty your bladder
- ☐ Loss of bladder control
- ☐ History of kidney stone
- ☐ History of urinary tract infections
- ☐ Sore or ulcers on the genital and or rectal areas
- ☐ Difficulty emptying your bladder

Endocrine:

- ☐ No problems experienced
- ☐ Bulge in the front of your neck (goiter)
- ☐ Bulging eyes
- ☐ Heat or cold intolerance
- ☐ Increased thirst
- ☐ Increased urination
- ☐ Excessive sweating

Hematological/ Lymphatic:

- ☐ No problems experienced
- ☐ Spontaneous bleeding
- ☐ Craving for eating ice or crunchy foods
- ☐ Pain on left upper abdominal areas
- ☐ Excessive bleeding with cuts or with teeth extraction
- ☐ Transfusion history
- ☐ Pain in fingers and or toes swelling
- ☐ Axilla (armpit)
- ☐ Groin
- ☐ Neck

Please check signs or symptoms you are currently experiencing:

Musculoskeletal:

- ☐ No problems experienced
- ☐ Muscle weakness
- ☐ Muscle wasting
- ☐ Muscle pain
- ☐ Bone pain
- ☐ History of joint pain or swelling
- ☐ Limitation of motion
- ☐ Deformity of joints

Neurological:

- ☐ No problems experienced
- ☐ Pain, where?_____
- ☐ Pins/needles sensation,where?_____
- ☐ Paralysis
- ☐ Fainting
- ☐ Seizure
- ☐ Tremors
- ☐ Transient paralysis or weakness of limbs, Where? _____
- ☐ Difficulty with coordination
- ☐ Difficulty walking
- ☐ Change in speech
- ☐ Difficulty with memory of recent events
- ☐ Headaches
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Transient blindness

Diet:

- ☐ Want to speak to a dietician
- ☐ Poor appetite
- ☐ Problems preparing or obtaining meals
- ☐ Unintentionally lost more than 10 pounds in the past 3 months
- ☐ Problems chewing or swallowing
- ☐ Mouth sores, or taste changes
- ☐ Food intolerances_____
- ☐ Using supplements e.g. Ensure or Boost

Are you on a special diet? _____

Psychological:

- ☐ No problems experienced
- ☐ Change in sleep pattern
- ☐ Thoughts of harming myself
- ☐ Hearing voices or seeing things that others don't
- ☐ Having problems with spouse
- ☐ Having problems with children
- ☐ Feelings of worthlessness or guilt
- ☐ Difficulty with memory or concentration
- ☐ Not enjoying life
- ☐ Increasing desire to be alone
- ☐ Change for the worse in my relationship with others
- ☐ Change in sexual interest or function
- ☐ Sad/ depressed/ tearful

_____ _____

Completed by: Date

_____M.D._____

Reviewed by: Date