Nebraska Hematology Oncology NHO

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH:** _____

PRIMARY CARE PHYSICIAN: _____ **REFERRING PHYSICIAN**: _____

PREFERRED PHARMACY: _____ **OCCUPATION**: _____

Please list all medications (including prescription, non-prescription, vitamins and herbal) you are currently taking:

Name of Drug	Dosage	Frequency	Reason for use	Prescribed by:

Please list any drug/food allergies you have and the type of reaction you have to that medication/food:

Name of Drug/Food Allergy	Type of Reaction

Please list any operations and/or procedures you have had and the year that you had them:

Type of Operation/Procedure	Year of Operation/Procedure

Please list any diseases/conditions you currently have or have had in the past:

Disease/condition	Current condition or Resolved	Type of Treatment

ADVANCE DIRECTIVES:

- Do you have a Do Not Resuscitate (DNR) / Do Not Intubate (DNI) order in place? □ No □ **Yes**; *please provide copy*
- Do you have a Living Will? □ No □ **Yes**; *please provide copy*
- Do you have a Power of Attorney for Healthcare? □ No □ **Yes**; *please provide copy*
- **If No, are you interested in learning more? □ No □ Yes**

Patient Name: _____

SOCIAL HISTORY:

SUBSTANCE	CURRENT USE	PAST USE	DAILY AMOUNT	YEAR/AGE STARTED	YEAR/AGE QUIT
Smoking Tobacco Use	□ YES □ NO	□ YES □ NO	Packs:		
Smokeless Tobacco Use	□ YES □ NO	□ YES □ NO			
Vaping Use	□ YES □ NO	□ YES □ NO			
Alcohol Use	□ YES □ NO	□ YES □ NO	Drinks:		
Marijuana Use	□ YES □ NO	□ YES □ NO			
Drug Use	□ YES □ NO	□ YES □ NO	Type:		
Caffeine Use	□ YES □ NO	□ YES □ NO	Drinks:		

SCREENING HISTORY:

- Date of last Mammogram *(if applicable)*: _____
- Date of last Colonoscopy *(if applicable)*: _____
- Date of last Pelvic Exam *(if applicable)*: _____
- Date of last Pap Smear *(if applicable)*: _____
- Date of last Bone Density *(if applicable)*:_____

IMMUNIZATION HISTORY:

- Date of last COVID-19 vaccine *(if applicable):* _____
- Date of last Influenza vaccine *(if applicable)*: _____
- Date of last Pneumonia vaccine *(if applicable)*: _____
- Date of last TDAP vaccine *(if applicable)*: _____
- Date of last Tetanus vaccine *(if applicable)*: _____
- Date of last Shingles vaccine *(if applicable)*: _____
- Name & Date of Other vaccines *(if applicable)*: _____

PAIN:	Are you Currently Experiencing Pain? □ YES □ NO
	If Yes, Location of Pain: _____
	Please Rate your Pain 1-10 (10 = worst) _____
	What are you doing for your Pain? _____
	My current pain management needs to be addressed: □ YES □ NO

HAVE YOU EXPERIENCED THE FOLLOWING?

PSYCHIATRIC:		Yes/No	COMMENTS/DESCRIPTION
	Depression (if Yes, please complete below)	□ YES □ NO	
	· Little interest or pleasure in doing things □ Not at All (0) □ Several Days (1) □ Over Half the Days (2) □ Nearly Every Day (3) · Feeling down, depressed or hopeless □ Not at All (0) □ Several Days (1) □ Over Half the Days (2) □ Nearly Every Day (3) Total: _____		

Patient Name: _____

HAVE YOU EXPERIENCED THE FOLLOWING?

PSYCHIATRIC cont.:		**Yes/No**	**COMMENTS/DESCRIPTION:**
	Anxiety	Y/N	
	Insomnia	Y/N	
	Other Mental Health Disorder	Y/N	
GENERAL:			
	Fatigue	Y/N	
	Fever/night sweats	Y/N	
	Difficulty with bathing/showering	Y/N	
	Difficulty with dressing	Y/N	
	Difficulty with walking/stair climbing	Y/N	
	Difficulty with meal preparation	Y/N	
	Confined to bed/chair more than 50% of day	Y/N	
EYES:			
	Visual changes/double vision	Y/N	
	Eyes yellow	Y/N	
ENT:			
	Decreased hearing	Y/N	
	Ringing in ears	Y/N	
	Nose bleeds/nasal discharge	Y/N	
	Hoarseness	Y/N	
	Sores/white patches in mouth	Y/N	
	Dental Problems	Y/N	
	Thyroid Problems	Y/N	
HEART:			
	Chest pain	Y/N	
	Ankle swelling	Y/N	
	Heart problems	Y/N	
	Blood Clots	Y/N	
	Irregularity/skipped beats	Y/N	
LUNGS:			
	Shortness of breath	Y/N	
	Cough with or without blood	Y/N	
	Wheezing	Y/N	
	Pulmonary Embolus	Y/N	
GASTROINTESTINAL:			
	Constipation	Y/N	
	Diarrhea	Y/N	
	Dietary Intake changes	Y/N	
	Dietary restrictions	Y/N	
	Fluid Intake changes	Y/N	
	Heartburn	Y/N	
	Nausea/vomiting	Y/N	
	Trouble swallowing	Y/N	
	Vomit blood	Y/N	
	Weight changes (loss/gain)	Loss/Gain	
	Weight changes (intentional/non-intentional)	I/Non-I	

PATIENT NAME: _____

HAVE YOU EXPERIENCED THE FOLLOWING?

GU-GENITOURINARY		**Yes/No**	**COMMENTS/DESCRIPTION:**
	Blood in urine	Y/N	
	Up at night to urinate	Y/N	
	Loss of bladder control	Y/N	
	Kidney stones	Y/N	
SKIN			
	Rash	Y/N	
	Skin itching	Y/N	
	Yellow skin (jaundice)	Y/N	
	Bruising	Y/N	
NEUROLOGICAL			
	Numbness/tingling	Y/N	
	Headache	Y/N	
	Dizziness	Y/N	
	Weakness	Y/N	
	Seizure	Y/N	
ENDOCRINE			
	Diabetes	Y/N	
	Heat/cold intolerance	Y/N	
	Thyroid problems	Y/N	
LYMPHATIC			
	Lumps or bumps	Y/N	
HEMATOLOGY			
	Bleeding problems	Y/N	
	Anemia	Y/N	
	Blood Transfusion history	Y/N	
MUSCULOSKELETAL			
	Muscle Weakness	Y/N	
	Gait (walking) problems	Y/N	
REPRODUCTIVE/SEXUAL			
	Changes in sexual desire	Y/N	
	Painful Intercourse	Y/N	
	Erectile dysfunction (males)	Y/N	
	Capable of Reproduction	Y/N	
	Fertility Preservation concerns	Y/N	
	Birth control (if yes-what method)	Y/N/NA	Method:
WOMEN:			
	Vaginal Discharge or bleeding	Y/N	
	Hot flashes	Y/N	
	Breast- lumps	Y/N	
	Menstrual Period-date of LMP	Y/N	
	Post-menopausal	Y/N	
	Hysterectomy	Y/N	