Nebraska Hematology Oncology NHO

New Patient & Family 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 implantable devices you have, i.e., pacemaker, insulin pump, etc.

Type of Device	Year Device was Placed

Patient Name: _____

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

  Are you interested in learning more about advance directives and/or advance care planning? ◯ No ◯ Yes

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	◯ 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

- Last COVID-19 vaccine (if applicable): ◯ Pfizer ◯ Moderna ◯ Johnson & Johnson Date: _____
- 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

Patient Name: _____

Have you experienced the following?

PSYCHIATRIC

Depression: ◯ Yes ◯ No (*if Yes, please complete below)

*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 Score: _____

Anxiety: ◯ Yes ◯ No

Insomnia ◯ Yes ◯ No

Other Mental Health Disorder ◯ Yes ◯ No

GENERAL

Fatigue ◯ Yes ◯ No

Fever/night sweats ◯ Yes ◯ No

Difficulty with bathing/showering ◯ Yes ◯ No

Difficulty with dressing ◯ Yes ◯ No

Difficulty with walking/stair climbing ◯ Yes ◯ No

Difficulty with meal preparation ◯ Yes ◯ No

Confined to bed/chair >50% of day ◯ Yes ◯ No

EYES

Visual changes/double vision ◯ Yes ◯ No

Eyes yellow ◯ Yes ◯ No

ENT

Decreased hearing ◯ Yes ◯ No

Ringing in ears ◯ Yes ◯ No

Nose bleeds/nasal discharge ◯ Yes ◯ No

Hoarseness ◯ Yes ◯ No

Sores/white patches in mouth ◯ Yes ◯ No

Dental problems ◯ Yes ◯ No

Thyroid problems ◯ Yes ◯ No

HEART

Chest pain ◯ Yes ◯ No

Ankle swelling ◯ Yes ◯ No

Heart problems ◯ Yes ◯ No

Blood clots ◯ Yes ◯ No

Irregularity/skipped beats ◯ Yes ◯ No

LUNGS

Shortness of breath ◯ Yes ◯ No

Cough with or without blood ◯ Yes ◯ No

Wheezing ◯ Yes ◯ No

Pulmonary embolus ◯ Yes ◯ No

GASTROINTESTINAL

Constipation ◯ Yes ◯ No

Diarrhea ◯ Yes ◯ No

Dietary intake changes ◯ Yes ◯ No

Dietary restrictions ◯ Yes ◯ No

Fluid intake changes ◯ Yes ◯ No

Heartburn ◯ Yes ◯ No

Nausea/vomiting ◯ Yes ◯ No

Trouble swallowing ◯ Yes ◯ No

Vomit blood ◯ Yes ◯ No

Weight changes (gain/loss) ◯ Yes ◯ No

Weight changes (intentional/non-intentional) ◯ Yes ◯ No

Patient Name: _____

Have you experienced the following?

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

When complete, please save document and email to: **medrecords@yourcancercare.com**

Patient Name: _____

Family Cancer History:

Your Biological Family	First Name	M/F	Cancer Type/ Diagnosis Age		Other Illnesses	Age at Death
Example	Jane	F	Ovarian	50	Heart failure	55
Children						
[redacted]						
Siblings						
[redacted]						
[redacted]						
Nieces		F				
[redacted]		F				
Nephews		M				
[redacted]		M				
Mother's Side of Family						
Mother		F				
Grandmother		F				
Grandfather		M				
Aunts/Uncles						
[redacted]						
First Cousins						
[redacted]						
Great Aunts/Uncles						
[redacted]						
Great Grandparents						
[redacted]						
Father's Side of Family						
Father		M				
Grandmother		F				
Grandfather		M				
Aunts/Uncles						
[redacted]						
First Cousins						
[redacted]						
Great Aunts/Uncles						
[redacted]						
Great Grandparents						
[redacted]						

Additional Family History Information:

Please mark below if you currently have, or in the past have had any of the following:

- ☐ Ovarian cancer, fallopian tube cancer, or primary peritoneal cancer?
- ☐ Pancreatic cancer?
- ☐ Metastatic prostate cancer?
- ☐ Breast cancer at age 45 or younger?
- ☐ Triple negative breast cancer?
- ☐ Male with breast cancer?
- ☐ Ashkenazi Jewish ancestry?
- ☐ *More than one diagnosis of breast cancer in your lifetime?
- ☐ *Breast cancer and at least 1 relative with either breast, prostate, ovarian, or pancreatic cancer?
- ☐ *Prostate cancer and at least 1 relative with either breast, prostate, ovarian, or pancreatic cancer?
- ☐ *Metastatic breast cancer?
- ☐ *Family member with colon cancer or endometrial cancer at age 50 or younger?
- ☐ *Family member with metastatic prostate cancer?
- ☐ *Known cancer gene mutation in you or your family member?

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