Nebraska Hematology Oncology NHO

4004 Pioneer Woods Drive
Lincoln NE 68506
Phone: (402) 484-4900

www.YourCancerCare.com
Fax: (402) 484-6456

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

NAME: _____**DATE OF BIRTH:** _____ **ETHNICITY:** _____**GENDER**: M F

OCCUPATION: _____ **REASON FOR VISIT TODAY**: _____

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

PREFERRED PHARMACY: _____

Please list all medications (including prescription, non-prescription, vitamins and herbal) you are currently taking (if your list is lengthy, you may provide us with a copy of all of your medications):

Name of Drug	Drug Dosage	Reason for use	Prescribed by:	Date Drug started

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

Date of last mammogram (if applicable): _____

Date of last colonoscopy (if applicable): _____

Date of last Pap Smear/Pelvic Exam (if applicable): _____

Date of last Bone Density (if applicable):_____

Immunizations: please fill in the year: Influenza: _____ Pneumovax: _____ Tetanus/TDAP: _____

Patient Name: _____

SOCIAL HISTORY:

SUBSTANCE	CURRENT USE	TYPE	AMOUNT/DAY	YEAR/AGE STARTED	YEAR/AGE QUIT
Tobacco Use	YES/NO	Smoke/chew	Packs:		
Alcohol Use	YES/NO	Beer/wine/ hard alcohol	Drinks:		
Drug Use	YES/NO	Ex: marijuana, heroin, cocaine, etc.			
Caffeine Use	YES/NO		Drinks:		

FAMILY HISTORY: In the section, "other significant diseases," include the following diseases/conditions if the family member has/had the disease/condition: Alzheimer's, Anemia, Arthritis, Asthma, Birth defect, bleeding disorder, Diabetes, Down's syndrome, Heart disease, Hypertension, Kidney Disease, Mental condition, Muscle disease, Neurologic Disorder, Respiratory disorder, Seizures/epilepsy, or skin disorder.

FAMILY	GENDER	L-Living or D-Deceased	Current Age or birthdate	Age at death	Cancer Diagnosis	Age at Diagnosis	Other significant diseases
Father							
Mother							
Sibling	M F						
Sibling	M F						
Sibling	M F						
Sibling	M F						
Maternal Grandmother	M F						
Maternal Grandfather	M F						
Maternal Aunt	M F						
Maternal Uncle	M F						
Paternal Grandmother	M F						
Paternal Grandfather	M F						
Paternal Aunt	M F						
Paternal Uncle	M F						
Niece/Nephew	M F						
Niece/Nephew	M F						
Child	M F						
Child	M F						
Child	M F						
Child	M F						
Child	M F						

Patient Name: _____

HAVE YOU EXPERIENCED THE FOLLOWING?

GENERAL:		**Yes/No**	**COMMENTS/DESCRIPTION:**
	Fatigue		
	Fever/night sweats		
	Difficulty with bathing/showering		
	Difficulty with dressing		
	Difficulty with walking/stair climbing		
	Difficulty with meal preparation		
	Confined to bed/chair more than 50% of day		
EYES:			
	Visual changes/double vision		
	Eyes yellow		
ENT:			
	Decreased hearing		
	Ringing in ears		
	Nose bleeds/nasal discharge		
	Hoarseness		
	Sores/white patches in mouth		
	Dental Problems		
	Thyroid Problems		
HEART:			
	Chest pain		
	Ankle swelling		
	Heart problems		
	Blood Clots		
	Irregularity/skipped beats		
LUNGS:			
	Shortness of breath		
	Cough with or without blood		
	Wheezing		
	Pulmonary Embolus		
GI-GASTROINTESTINAL:			
	Constipation		
	Diarrhea		
	Dietary Intake changes		
	Dietary restrictions		
	Fluid Intake changes		
	Heartburn		
	Nausea/vomiting		
	Trouble swallowing		
	Vomit blood		
	Weight changes (loss/gain)		
	Weight changes (intentional/non-intentional)		
PAIN			
	Currently experiencing pain		
	Pain Intensity 1-10		
	Pain Location		

PATIENT NAME: _____

HAVE YOU EXPERIENCED THE FOLLOWING?

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