SUSQUEHANNA HEALTH CANCER CENTER
HEMATOLOGY & ONCOLOGY
NEW PATIENT HEALTH QUESTIONNAIRE

Name: ____**Date of Birth:**____________________

What is the reason for your visit today? ____

What doctor referred you to this office? ____

PAST MEDICAL HISTORY: Do you have any of the following:

Please check all that apply

Anxiety /depression	☐
Asthma	☐
Atrial Fibrillation	☐
BPH (enlarged prostate)	☐
Cirrhosis	☐
COPD (or emphysema)	☐
Diabetes	☐
GERD (heartburn/indigestion	☐
Hepatitis	☐
High Cholesterol	☐
HTN (high blood pressure)	☐
MI (heart attack)	☐
Thyroid- (low or high)	☐
Osteoarthritis	☐
Seizures	☐
Stroke	☐
DVT (blood clot in leg)	☐
PE (pulmonary embolism)	☐

SURGICAL HISTORY

Appendectomy (appendix out)	☐ Date_________
Biopsy of _______________	☐ Date_________
C-Section	☐ Date_________
Cataract Removal	☐ Date_________
Colonoscopy	☐ Date_________
Coronary Bypass	☐ Date_________
Hysterectomy (uterus removed)	☐ Date__________
Ovaries Removed	☐ Date__________
Laminectomy (spine surgery)	☐ Date__________
Kyphoplasty (spine surgery with cement)	☐ Date__________
Pacemaker	☐ Date__________
Tonsillectomy	☐ Date__________
Tubal Ligation (tubes tied)	☐ Date__________
Knee Replacement	☐ Date__________
Hip Replacement	☐ Date__________
Rotator Cuff Repair	☐ Date__________
Cholecystectomy (gallbladder out)	☐ Date__________

OTHER:____

____

____

FOR WOMEN:

How many pregnancies______

How many live births________

Age at first birth____________

# of interrupted pregnancies______

Age at first period______________

Last pap smear___________

Last mammogram__________

Age of menopause__________

Reason: Natural Surgery Other (circle one)

Last menstrual period__________every _____days

Dr. Agbemabiese-Dr. Behrens-Dr. Pineda-Dr. Robinson-Dr. Wyshock-Laura Balmer CRNP-Sarah Moncado-PA

RN Initials: _____

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FAMILY HISTORY: **Please complete the section in its entirety and provide as much detailed information as possible.**

RELATIVE	**MEDICAL PROBLEMS**: (i.e. heart failure, breast cancer, etc.)	**Age at Diagnosis**	**Deceased?**	**Age at Death**
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Father				
Aunts (w/Cancer)				
Uncles (w/Cancer)				
Sisters (Total #_____)				
Brothers (Total #____)				
Children (please list ages of all children)				
Spouse				

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SOCIAL HISTORY: Please check all that apply:

DO YOU:		HOW MUCH Ex: 1 pack a day or 6 beers a month	HOW OFTEN Ex:1 pack a day or 6 beers a month	HOW LONG
Currently smoke?	Pipe ☐ Cigarettes ☐ NO ☐			
Did you ever smoke?	Yes ☐ No ☐ Quit date:____________			
Chew Tobacco?	Yes ☐ No ☐			
Drink Alcohol? (Even if it's only social)	Beer ☐ Wine ☐ Liquor ☐ Never ☐			

Mobility: Ambulate independently with cane, walker or wheelchair bound? ______________________________

Occupation:____How long?____________________

Hobbies:______________________(i.e.painting,gardening) Exercise (i.e.walking____

Were you ever exposed to toxins/chemicals? Yes No
If yes, what were you exposed to: ____

Do you follow a special diet? Circle any that apply REGULAR/ SOFT/FEEDING TUBE/LIQUID/SUPPLEMENTS/Diabetic

Are you: Married ☐ Single ☐ Divorced ☐ Widow ☐

Do you live: Alone ☐ With spouse/significant other ☐ With family ☐

Do you feel safe in your home? Yes ☐ No ☐

Do you have thoughts of harming yourself? Yes ☐ No ☐

Will you need assistance traveling to and from the Cancer Center? Yes ☐ No ☐

Are you having financial worries about your testing or potential treatment: Yes ☐ No ☐

Do you have a Living Will/Advance Directive? Yes ☐ No ☐

Would you like to speak with someone about a Living Will/Advance Directive? Yes ☐ No ☐

Do you have a Healthcare Power of Attorney? Yes ☐ No ☐

ALLERGIES: **Please list all medication allergies and the reaction**: No Medication Allergies ☐

1.____ 3.____

2.____4.____

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RETAIL AND/OR MAILORDER PHARMACY

PHARMACY NAME: ________________________**MAIL ORDER COMPANY:** ___________________

MEDICATION LIST: Please list **ALL** medications you take, including over the counter medications/supplements

MEDICATION	DOSE	ROUTE (by mouth, injection)	FREQUENCY

RN Initials:___

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Review of Systems: Please check YES to those that apply

	SYMPTOM	YES	Please Explain
Constitutional	LOSS OF APPETITE	☐	
	WEIGHT LOSS	☐	
	SHAKING CHILLS	☐	
	NIGHT SWEATS	☐	
	FEVER	☐	
Eyes	BLURRED VISION	☐	
	DOUBLE VISION	☐	
	CATARACTS	☐	
	GLAUCOMA	☐	
ENMT	HEARING LOSS	☐	
	DYSPHAGIA (pain swallowing)	☐	
	DRY MOUTH	☐	
	MOUTH SORES	☐	
	SINUS INFECTIONS	☐	
	EPISTAXIS	☐	
Endocrine	DIABETES	☐	
	HOT FLASHES	☐	
	THYROID DISEASE	☐	
Hem/Lymph	BLEEDING	☐	
	BLOOD CLOT	☐	
	BRUISING	☐	

	HISTORY OF ANEMAI/LOW BLOOD	☐	
	TRANSFUSIONS	☐	
	ENLARGED LYMPH NODES	☐	
Breast	BREAST MASSES	☐	
	NIPPLE DISCHARGE	☐	
	NIPPLE INVERSION	☐	
	BREAST PAIN	☐	
Respiratory	COUGH	☐	
	SPUTUM PRODUCTION	☐	
	SHORTNESS OF BREATH	☐	
	WHEEZING	☐	
	COUGHING BLOOD	☐	
Cardio	CHEST PAIN	☐	
	PALPITATIONS	☐	
	ANKLE SWELLING	☐	
GI	ABDOMINAL PAIN	☐	
	DIARRHEA	☐	
	CONSTIPATION	☐	
	HEARTBURN	☐	
	VOMITING	☐	
	BLACK STOOLS	☐	
	BLOOD IN STOOLS	☐	
	HEMORRHOIDS	☐	
	HERNIA	☐	
GU	BURNING WITH URINATION	☐	
	URINARY FREQUENCY	☐	

Musculoskeletal	ARTHRITIS	☐	
	BONE PAIN	☐	
	MUSCLE WEAKNESS	☐	
Skin/Integ	DRY SKIN	☐	
	ITCHING	☐	
	RASH	☐	
	HIVES	☐	
Neuro	DIZZINESS	☐	
	HEADACHE	☐	
	PARALYSIS	☐	
Psych	DEPRESSION	☐	
	ANXIETY	☐	
Other:		☐	

Please provide us with your cell phone#:____

Please provide us with your email address:____

RN Initials:________