

JACKSONVILLE HEMATOLOGY ONCOLOGY
501 S. Ragsdale, 4th Floor
Jacksonville, TX 75766
(903) 589-1327 (903) 589-1862 fax

Name _____ Date of Birth _____ Today's Date _____

Doctor(s) to whom we should send report

Primary care doctor: _____

Surgeon: _____

Other specialists: _____

What are the primary reasons for your coming to see the doctor?

What tests, x-rays, biopsies, surgeries, CT or MRI scans, endoscopies, mammograms, ultrasounds and treatments have you had that pertain to this **primary reason** for coming? Please include dates, locations, and the physician who performed or ordered these tests or treatments.

SURGICAL HISTORY

Please list any surgery you have had, with dates and hospitals. (ex. *Gall bladder surgery, 1998, ETMC Tyler*)

Have you ever had problems with anesthesia? If yes, please explain.

MEDICAL HISTORY

Please list medical problems, past and present such as high blood pressure, cardiac disease, diabetes, emphysema, etc. (ex. *High blood pressure since 1985 or heart disease with a heart attack in 1989 and cardiac catheterization in 1995*)

MEDICAL HISTORY (continued)

Please list all hospital stays, reasons, dates, and locations for non-surgical admissions. (ex. *Pneumonia, Spring 1998, ETMC Tyler*)

Y N Have you ever had blood transfusion? If yes, please indicate what kind of transfusion, how many units, and date of transfusion. Please indicate if you had any complicating transfusion reaction.

GYNECOLOGIC HISTORY (female patients)

Age at first menstrual period _____ Last menstrual period _____

Y N Have you had a hysterectomy?

Y N Were your ovaries removed?

Number of pregnancies _____ Number of live births _____

Your age at first pregnancy _____

Y N Did you breast-feed your children?

Y N Have you ever taken birth-control pills? If yes, for how long? _____

Y N Could you possibly be pregnant now?

Y N Have you ever taken post-menopausal estrogen supplements? If yes, what medication, when, and for how long? _____

Date and location of

Last mammogram: _____

Last PAP test: _____

Last Bone Density study (for osteoporosis) _____

PSYCHIATRIC HISTORY

Y N Have you ever been hospitalized for a psychiatric problem? If yes, please indicate diagnosis, hospital, and dates _____

Y N Are you currently depressed? If yes, please explain _____

Y N Have you been depressed in the past and required medication?

Y N Do you have anxiety or panic attacks?

Y N Have you ever attempted suicide? If yes, please explain _____

ALLERGIES

Do you have any allergies? Please list and explain. (ex. *Penicillin causes skin rash or strawberries causes hives*)

MEDICATIONS

Please list all your current medications, both prescription and non-prescription. Please include all vitamins, herbal therapies, and alternative (non-conventional) medicines. (ex. *Tamoxifen, 10 mg twice a day*)

FAMILY HISTORY

Please indicate if any of your family members have/had any of these diseases:

- BREAST CANCER COLON CANCER LUNG CANCER SKIN CANCER BRAIN CANCER LEUKEMIA
- LYMPHOMA OVARIAN CANCER OTHER CANCER _____
- HEART DISEASE HIGH BLOOD PRESSURE
- DIABETES STROKE KIDNEY DISEASE HEMOPHILIA SICKLE-CELL ANEMIA OR TRAIT
- EXCESSIVE CLOTTING OR BLEEDING DISORDER

Mother: Alive? Y N Current Age _____ or Age at Death _____

Father: Alive? Y N Current Age _____ or Age at Death _____

Brother(s): Alive? Y N Current Age(s) _____ or Age(s) at Death _____

Sister(s): Alive? Y N Current Age(s) _____ or Age(s) at Death _____

Maternal Grandmother: Alive? Y N Current Age(s) _____ or Age(s) at Death _____

Maternal Grandfather: Alive? Y N Current Age(s) _____ or Age(s) at Death _____

Paternal Grandmother: Alive? Y N Current Age(s) _____ or Age(s) at Death _____

Paternal Grandfather: Alive? Y N Current Age(s) _____ or Age(s) at Death _____

FAMILY HISTORY (continued)

Children: Alive? Y N Current Age(s) _____ or Age(s) at Death _____
 _____ Phone _____
 _____ Phone _____
 _____ Phone _____
 _____ Phone _____
 _____ Phone _____

SOCIAL HISTORY

Marital Status: Single Married Divorced Separated Widowed

With whom did you live? _____

How far did you go in school? _____

Y N Are you employed? If yes, indicate employer _____

Y N Are you retired? If yes, indicate former employer _____

Y N Do you smoke? If yes, how much and how long _____

Y N Did you smoke and stop? If yes, how much and how long _____

Y N Do you use other tobacco products? If yes, what product, how much and how long? _____

Y N Do you drink alcohol? If yes, how much and how long _____

Y N Do you drink alcohol and stop? If yes, how much and how long _____

Y N Do you use or have you used any drugs (marijuana, cocaine, heroin, etc.)? If yes, what type, how much, how long, and route administered _____

Y N Are you at risk for exposure to the HIV/AIDS virus (IV drug use, homosexuality, multiple sexual partners).

Y N If yes, do you want an HIV/AIDS blood test?

REVIEW OF SYSTEMS

Systematic Symptoms (please indicate by circling if you have or have ever had any of these symptoms.)

FEVER CHILLS NIGHT SWEATS WEIGH LOSS WEIGHT GAIN CHANGE IN APPETITE

If yes, please explain _____

Skin

Y N

Rash _____

Skin cancer _____

Moles that have changed or bleed _____

Easy bruised _____

Itching _____

Ulcers or sores _____

Lymph Nodes

Y N

Swollen glands _____

Head, eyes, ears, throat, sinuses

Y N

Headache _____

Visual change _____

Hearing loss _____

Ringing in ears _____

Difficulty swallowing _____

Dental problems _____

Mouth sores _____

Sinus drainage or infections _____

Nose bleeds _____

Dryness of the eyes _____

Dryness of the mouth _____

Thyroid

- Y N
 Low thyroid activity (hypothyroidism) _____
 High thyroid activity (hyperthyroidism) _____
 Heat or cold intolerance _____
 Nodules, masses, or goiter _____

Breasts

- Y N
 Breast pain _____
 Nipple discharge _____
 Fibrocystic disease _____
 Breast mass or nodule _____

Lungs

- Y N
 Cough _____
 Sputum (mucous or phlegm) production _____
 Coughing blood _____
 Shortness of breath _____
 Chest pain _____
 Pleurisy _____
 Wheezing _____

Heart

- Y N
 Chest pain or angina _____
 Palpitation _____
 Heart failure _____
 Ankle swelling _____
 Heart murmur _____

Stomach/Gastrointestinal

- Y N
 Nausea _____
 Vomiting _____
 Blood seen _____
 Stomach pain _____
 Difficult or painful swallowing _____
 Heartburn _____
 Jaundice _____
 Constipation _____
 Diarrhea _____
 Hemorrhoids _____
 Blood in your stools _____
 Black, tarry stools _____
 Change in stool caliber (thickness of bowel movement) _____
 Incontinence of stool _____

(Y) (N)

- Have you ever had endoscopy (scoping) of the esophagus and stomach? _____
 Have you ever had endoscopy of the esophagus and stomach? _____

Genital/Urinary

- Y N
 Difficulty passing urine _____
 Pain on urination _____
 Frequent need to void _____
 Need to void more than once through the night _____
 Blood in urine _____
 Incontinence of urine _____
 Impotence _____
 Sexual dysfunction (female patients) _____
 Pain with sexual relations _____
 Hot flashes _____
 Vaginal dryness _____
 Sexually transmitted diseases (syphilis, gonorrhea, HIV/AIDS, herpes) _____
 Excessively heavy menstrual periods _____
 Post menopausal bleeding _____
 Infertility _____

Joints, Muscles, & Bones

- Y N
 Back Pain _____
 Joint stiffness or pain _____
 Muscle aches or pain _____
 Muscle weakness _____

Neurological

- Y N
 Stroke _____
 Weakness _____
 Numbness _____
 Confusion _____
 Difficulty speaking _____
 Memory loss _____
 Difficulty walking _____
 If yes, do you use a (circle all that apply)
 CANE WALKER WHEELCHAIR
 Change in coordination _____

(Y) (N)

Change in personality or behavior _____

Fainting spells or blackout spells _____

Seizures _____

Involuntary movement disorders _____

Difficulty sleeping _____

VACCINATIONS (date received)

Last tetanus shot _____

Last flu shot _____

Pneumovax (pneumonia shot) _____

Last PPD (tuberculosis or TB skin test) _____

Prevnar _____

Hepatitis B shots _____

Last PSA (prostate cancer screening test for men only) _____

Last digital exam of the prostate (rectal exam, men only) _____

Any recent foreign travel (where and when)

