TYLER HEMATOLOGY ONCOLOGY
721 A CLINIC DRIVE
TYLER, TEXAS 75701
903.592.6152

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 possible 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)
____
____
____
____
____
____