UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS Hematology/Oncology **Health History Questionnaire - New Patient - Hematology/Oncology**	MRN: NAME: BIRTHDATE: CSN:

Date of appointment: _____/_____/_____ (mm/dd/yyyy)

Please fill this form out as completely as possible and bring this to your appointment.

Past Medical History (please check any medical problems that you have had in the past)

Cancer History

☐Bladder cancer	☐Esophageal cancer	☐Pancreatic cancer
☐Bone cancer	☐Leukemia	☐Prostate cancer
☐Brain cancer	☐Lung cancer	☐Skin cancer
☐Breast cancer	☐Lymphoma	☐Small intestine cancer
☐Cervical cancer	☐Multiple Myeloma	☐Stomach cancer
☐Colon cancer	☐Ovarian cancer	☐Uterine cancer

☐Other (list)_____

Medical History

☐Allergies	☐COPD (lung disease)	☐Nerve/muscle disease
☐Alzheimer's disease	☐Depression	☐Osteoporosis
☐Anemia	☐Diabetes mellitus	☐Polycythemia vera
☐Anxiety	☐Emphysema	☐Polymyalgia rheumatic
☐Arthritis	☐Fibrocystic breast	☐Rheumatoid arthritis
☐Asthma	☐GERD (heartburn)	☐Seizures
☐Bleeding disorder	☐Glaucoma	☐Sickle cell anemia
☐Blood transfusion	☐Heart murmur	☐Stroke
☐Breast problems	☐HIV/AIDS	☐Substance abuse
☐Cataracts	☐Hypertension (high blood pressure)	☐Thyroid disease
☐Chronic bronchitis	☐Kidney disease	☐TIA (transient ischemic attack)
☐Cirrhosis	☐Lupus	☐Tuberculosis
☐Clotting disorder	☐Meningitis	☐Ulcers
☐Congestive heart failure	☐Myocardial infarction (heart attack)	☐Other (specify): _____

Surgical History (Check any surgeries you have had and the date of surgery if you know it):

☐Appendectomy	☐Biopsy	☐Hysterectomy
☐Arterial bypass	☐Cholecystectomy	☐Splenectomy
☐Back surgery	☐Other (list):_____	

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Family History
Check below to report problems your family members have had. Please state the age when they had the problem if you know it.
☐I was adopted so I do not know my family history

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Anesthesia Problems							
Bleeding disorder							
Blood count disorder							
Breast cancer							
Cancer							
Clotting disorder							
Colon cancer							
Diabetes							
Heart disease							
Hypertension							
Kidney disease							
Leukemia							
Lung cancer							
Lymphoma							
Melanoma							
Multiple myeloma							
Ovarian cancer							
Sarcoma							
Stroke							
Other (specify)							
Alive (Yes, No or N/A=Not Applicable							

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Social History

Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Significant Other ☐ Single
☐ Widowed ☐ Unknown ☐ Other (specify):_____

I currently live: ☐Alone ☐With family ☐With friends ☐With significant other

Do you have children? ☐No ☐Yes: Ages_____

What is your occupation? _____

Do you ever drink alcohol? ☐Yes ☐No
If yes, please indicate the quantity per week of each:

- Glasses of wine _____
- Cans/bottles of beer _____
- Shots of liquor _____
- Drinks containing 0.5 oz of alcohol _____

Are you sexually active? ☐Yes ☐No ☐Not currently

If yes, is/are your partner(s): ☐Male ☐Female ☐Both

Type of birth control/protection currently used:

☐Not having sex (Abstinence) ☐Condom ☐Injection ☐IUD (Intrauterine Device)

☐Oral Contraceptives (Pill) ☐Patch ☐Post-menopausal ☐None ☐Other (specify): _____

Do you use drugs? ☐Yes ☐No

If you use drugs, how many times per week? _____

What type(s) of drugs do you use? _____

Check one of the following about smoking tobacco:

☐Never smoked ☐Former smoker ☐Smoke some days ☐Smoke every day ☐Exposed to second hand smoke

If you smoke or used to smoke, how many packs do/did you smoke per day? _____

How many years did you smoke/have you smoked? _____

If you quit, when did you quit? _____

Do you use “smokeless tobacco”? (Select one below)

☐Former user

☐Current user

☐Never used

If you quit, when did you quit? _____

Are you ready to quit smoking and / or using smokeless tobacco? ☐Yes ☐No

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Patient Intake Information

Family physician:

Name _____ Specialty _____

Address _____ Phone Number _____

City _____ State _____ Zip _____ Fax _____

Specialty physician: (e.g., surgeon, oncologist, other)

Name _____ Specialty _____

Address _____ Phone Number _____

City _____ State _____ Zip _____ Fax _____

Name _____ Specialty _____

Address _____ Phone Number _____

City _____ State _____ Zip _____ Fax _____

Pharmacy Information:

Pharmacy Name _____

Address _____ Phone Number _____

City _____ State _____ Zip _____ Fax _____

To whom should we send information about your visits at UMHS? _____

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Additional Medical History

Hospitalizations	*Please list any hospitalizations* (other than normal pregnancies or deliveries)
Date	Description

Have you ever had a transfusion or been exposed to other blood products? ☐Yes ☐No
If yes, please describe the situation: _____

_____

Cancer Diagnosis and Treatment

Type of Cancer	Type of Treatment		
	Surgery	☐No	☐Yes (what kind?) _____
	Chemotherapy	☐No	☐Yes (what agents?) _____
	Radiation	☐No	☐Yes (to where?) _____
	Hormonal Therapy	☐No	☐Yes
	Other:	_____	
	Surgery	☐No	☐Yes (what kind?) _____
	Chemotherapy	☐No	☐Yes (what agents?) _____
	Radiation	☐No	☐Yes (to where?) _____
	Hormonal Therapy	☐No	☐Yes
	Other (specify):	_____	
	Surgery	☐No	☐Yes (what kind?) _____
	Chemotherapy	☐No	☐Yes (what agents?) _____
	Radiation	☐No	☐Yes (to where?) _____
	Hormonal Therapy	☐No	☐Yes
	Other (specify):	_____	

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Review of Systems: *Please circle any symptom that you feel currently*

Category	Issues	No problems
General	Appetite change fatigue fever sweats weight loss weight gain weakness	☐
Skin	Itching rash mole change	☐
Eyes	Vision change cataracts glaucoma	☐
Ears / nose / mouth	Dizziness ringing in ears hoarseness sore throat runny nose nosebleeds	☐
Lungs	Cough shortness of breath chest pain coughing blood wheezing	☐
Heart	Chest pain palpitations fainting episodes leg pains sleeping with more than one pillow	☐
GI	Abdominal pain nausea vomiting diarrhea constipation jaundice black stools blood in stools difficulty swallowing hemorrhoids	☐
Genitourinary	Painful urination increased frequency urgency blood in urine kidney stones urinating at night	☐
Musculoskeletal	Arthritis stiffness swelling weakness backache	☐
Nervous system	Headache seizure dizziness tremors memory loss paralysis numbness/tingling anxiety depression personality change suicidal thoughts	☐
Male reproductive	Testicular pain swelling sexual dysfunction	☐
Female reproductive	Pelvic pain loss of period abnormal bleeding sexual dysfunction	☐
Hematologic	Bruising bleeding recurrent infections	☐
Lymph nodes	Enlargement tenderness	☐

_____ _____/_____/_____ (mm/dd/yyyy)

Printed name of person who completed this form Date

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