Department of Medicine - Division of Hematology and Medical Oncology

PATIENT SELF- ASSESSMENT FORM

Please complete the information below to the best of your ability.

Personal Information:

Name: _____Date of Birth: _____
Address: _____
City: _____State: _____ Zip: _____
Telephone: _____ E-mail: _____

Referring Physician Information:

Please print full name of referring physician: _____
Address: _____ City: _____Zip: _____
Telephone: _____ Fax: _____

Pharmacy: _____
Address: _____
Telephone: _____ Fax: _____

Please list any additional physicians you would like reports from today's visit to be sent to:

Physician's Name Address Telephone/Fax

1 _____
2 _____
3 _____

Reason for your visit:

_____
_____
_____
_____
_____

How did you hear about us?
☐Physician referral ☐Friend/family member ☐Other organization
☐Internet ☐Other**:** _____

Medical History:

Have you been or are you currently being treated for the following conditions?

Cancer ☐YES ☐NO
If yes, specify type(s) of cancer(s) and date(s) of diagnosis: _____
_____

Blood problems ☐YES ☐NO
If yes, specify type(s) of problem (s) and date(s) of diagnosis: _____
_____

Have you received the flu vaccine this year? ☐YES ☐NO
If yes, approximate date: _____
Have you ever received the pneumonia vaccine? ☐YES ☐NO
If yes, approximate date: _____

Medical History Continues:

Heart attack	☐YES	☐NO
Congestive heart failure	☐YES	☐NO
High blood pressure	☐YES	☐NO
High cholesterol	☐YES	☐NO
Peripheral vascular disease	☐YES	☐NO
Dementia	☐YES	☐NO
Stroke	☐YES	☐NO
Pulmonary disease/COPD	☐YES	☐NO
Autoimmune condition	☐YES	☐NO
Diabetes	☐YES	☐NO
Peptic ulcer disease	☐YES	☐NO
Liver disease	☐YES	☐NO
Viral hepatitis	☐YES	☐NO
Paralysis	☐YES	☐NO
Osteoporosis	☐YES	☐NO
Kidney failure	☐YES	☐NO
Psychiatric problems	☐YES	☐NO
Hereditary conditions	☐YES	☐NO
Blood clots in your legs	☐YES	☐NO
Blood clots in your lungs	☐YES	☐NO

Surgical History:

Have you ever undergone any surgical procedure(s): ☐ YES ☐ NO
If "yes", please specify including dates:

_____
_____
_____

Family History:

Please indicate your family members' medical history as below:

	First Name	Alive? (Y/N)	Age	Heart Disease?	High Cholesterol?	Diabetes?	Stroke?	Cancer?	Blood clots?
Father									
Mother									
Grandmother									
Grandfather									
Son									
Daughter									
Brother									
Sister									
Other									

For any family member you have indicated "yes" for cancer history above, please list the specific details below as well as the age of onset of the disease.

Family member Age at onset/ death Type of Cancer

_____
_____
_____
_____
_____

Race:

Do you consider yourself (check that apply):

☐ White
☐ Black
☐ Asian or Pacific Islander
☐ American Indian or Alaska Native

Ethnicity:

Do you consider yourself of Hispanic or Latino or Spanish origin: ☐ YES ☐ NO

Social History:

Do you currently smoke? ☐ YES ☐ NO Did you ever smoke? ☐ YES ☐ NO

Did you ever use chewing tobacco or snuff? ☐ YES ☐ NO
If yes to any question, please indicate type of tobacco, amount per day, number of years, and quit date.
_____
_____

Do you currently drink? ☐ YES ☐ NO
If yes, please indicate type(s) of alcohol and approximate number of drinks per week for each type.
_____

Do you currently use recreational drugs: ☐ YES ☐ NO
If "yes", please specify:
_____

Socioeconomic History:

Do you currently work? ☐ YES ☐ NO

Occupation: _____ Years of education: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____
Spouse name: _____ Telephone: _____

Allergies:

Do you have any **ALLERGIES** to medications? ☐ YES ☐ NO
If yes, please list medications **AND** reactions:
_____
_____

Medication List:

Please list medications that you are currently taking, including anything over the counter:

Medication (name)	**Amount**	**Frequency taken (daily, every 6 hours, etc.)**	**Approximate start date of medication**
Example: metoprolol	*25mg*	*Once daily*	*2013*

Male:	**YES**	**NO**
Testicular pain/lumps	☐	☐
Prostate problems	☐	☐
Reduced libido/desire	☐	☐

Female:	**YES**	**NO**
Irregular periods	☐	☐
Vaginal yeast infections	☐	☐
Reduced libido/desire	☐	☐
Pregnant or nursing	☐	☐
Planning a pregnancy	☐	☐

Last Mammogram: _____

Current form of birth control: _____
Last menstrual cycle: _____
Age at onset of menstruation: _____
Age at onset of menopause: _____

REVIEW OF SYSTEMS: Please indicate **IF YOU ARE CURRENTLY EXPERIENCING** any of the following signs and/or symptoms:

	YES	NO
CONSTITUTIONAL		
Recent change in weight?	☐	☐
Fevers?	☐	☐
Chills?	☐	☐
Night sweats?	☐	☐
Decreased appetite?	☐	☐
Fatigue?	☐	☐
Inability to sleep?	☐	☐
EYES		
Recent change in vision?	☐	☐
Double vision?	☐	☐
Eye pain?	☐	☐
EARS/NOSE/MOUTH/THROAT		
Hearing loss?	☐	☐
Ringing in the ears?	☐	☐
Pain in the ears?	☐	☐
Nasal congestion?	☐	☐
Runny nose?	☐	☐
Post nasal drip?	☐	☐
Nosebleeds?	☐	☐
Sore throat?	☐	☐
CARDIOVASCULAR		
Chest pains?	☐	☐
Palpitations?	☐	☐
Inability to sleep lying flat?	☐	☐
Swelling in the legs or feet?	☐	☐
Muscle pains in the legs with walking?	☐	☐
Awakening feeling short of breath?	☐	☐
Lightheadedness?	☐	☐
Loss of consciousness?	☐	☐
Decreasing exercise tolerance?	☐	☐
RESPIRATORY		
Shortness of breath?	☐	☐
Coughing up sputum/phlegm?	☐	☐
Coughing up blood?	☐	☐
Wheezing?	☐	☐
GASTROINTESTINAL		
Nausea?	☐	☐
Vomiting?	☐	☐
Abdominal pains?	☐	☐
Diarrhea?	☐	☐
Constipation?	☐	☐
Heartburn/reflux?	☐	☐
Blood in the stool?	☐	☐

	YES	NO
MUSCULOSKELETAL		
Pains in the joints (knees, hips, etc.)?	☐	☐
Muscle pains?	☐	☐
Bone fractures?	☐	☐
Pain in the bones (not joints)?	☐	☐
GENITOURINARY		
Need to urinate frequently?	☐	☐
Need to urinate suddenly and urgently?	☐	☐
Frequent urination at night (>1X)?	☐	☐
Blood in the urine?	☐	☐
Pain while urinating?	☐	☐
Urinary incontinence?	☐	☐
DERMATOLOGICAL		
New rashes?	☐	☐
New ulcers?	☐	☐
Recent hair loss?	☐	☐
Recent change in skin?	☐	☐
NEUROLOGICAL		
New weakness?	☐	☐
New severe headaches?	☐	☐
New memory loss?	☐	☐
New seizures?	☐	☐
Sensation of the world spinning?	☐	☐
ENDOCRINOLOGIC		
New intolerance to heat?	☐	☐
New intolerance to cold?	☐	☐
Increased frequency of urination?	☐	☐
Increased need to drink fluids?	☐	☐
HEMATOLOGICAL		
Easy bleeding?	☐	☐
Easy bruising?	☐	☐
Swollen glands/lymph nodes?	☐	☐
Current use of coumadin/Pradaxa/Xarelto?	☐	☐
ALLERGIC/IMMUNOLOGIC		
Diffuse itching?	☐	☐
Anaphylaxis?	☐	☐
Swelling of the throat?	☐	☐
PSYCHIATRIC		
Depressed mood?	☐	☐
Inability to enjoy anything?	☐	☐
Anxiety?	☐	☐
Suicidal thoughts?	☐	☐
Hallucinations?	☐	☐