



HEMATOLOGY & ONCOLOGY QUESTIONNAIRE

Today's Date _____ First Name _____ Last Name _____ Date of Birth _____

FEMALE PATIENTS ONLY

Age at onset of menstrual period _____ Number of live births _____ Breast Pain Yes No
 Last menstrual period _____ Age menopause occurred _____ Breast Lumps/Masses Yes No
 Number of pregnancies _____ Change in Nipple Yes No

EXTENDED FAMILY HISTORY OF CANCER OR BLOOD DISORDERS (If no family history, proceed to signature line.) Immediate family on separate page.

| Family Member | Maternal History (Mother) | Paternal History (Father) |
|---------------|---|---|
| Grandmother | Age at onset: Type of cancer/blood disorder: | Age at onset: Type of cancer/blood disorder: |
| Grandfather | Age at onset: Type of cancer/blood disorder: | Age at onset: Type of cancer/blood disorder: |
| Uncles | Age at onset: Type of cancer/blood disorder: | Age at onset: Type of cancer/blood disorder: |
| | Age at onset: Type of cancer/blood disorder: | Age at onset: Type of cancer/blood disorder: |
| Aunts | Age at onset: Type of cancer/blood disorder: | Age at onset: Type of cancer/blood disorder: |
| | Age at onset: Type of cancer/blood disorder: | Age at onset: Type of cancer/blood disorder: |
| Cousins | Age at onset: Type of cancer/blood disorder: | Age at onset: Type of cancer/blood disorder: |
| | Age at onset: Type of cancer/blood disorder: | Age at onset: Type of cancer/blood disorder: |

REVIEW OF SYSTEMS: Please check any new symptoms you have experienced in the last MONTH.

Constitutional/General

- Yes No Fever
- Yes No Chills
- Yes No Heavy Sweating/Night Sweats
- Yes No Loss of Appetite
- Yes No Sleep Disturbances
- Yes No Unexplained Weight Loss/Gain
- Other: _____

Cardiovascular

- Yes No Chest Pain or Discomfort
- Yes No Swelling Feet, Ankles, Legs
- Yes No Irregular Heartbeat
- Yes No Heart Attack
- Yes No Palpitations
- Yes No Varicose Veins
- Other: _____

Genitourinary

- Yes No Painful urination
- Yes No Urinary Frequency
- Yes No Loss of Urinary Control
- Yes No Enlarged Prostate
- Yes No Difficulty Urinating
- Other: _____

Eyes

- Yes No Blurry Vision
- Yes No Double Vision
- Yes No Wear Glasses
- Other: _____

Gastrointestinal

- Yes No Abdominal Pain
- Yes No Nausea/Vomiting
- Yes No Indigestion/Heartburn
- Yes No Blood in Stools
- Yes No Change in Bowel Habits
- Yes No Rectal Bleeding
- Yes No Diarrhea
- Yes No Constipation
- Yes No Swallowing Difficulties
- Other: _____

Skin

- Yes No Skin Rash
- Yes No Itching
- Yes No Discoloration
- Yes No Lumps or Masses
- Other: _____

Ear/Nose/Throat

- Yes No Sore Throat
- Yes No Mouth Sores
- Yes No Nasal Congestion/Sinus Issues
- Yes No Hearing Loss
- Other: _____

Musculoskeletal

- Yes No Joint Pain
- Yes No Joint Swelling
- Yes No Back Pain
- Yes No Limitation of Motion
- Yes No Neck Pain
- Yes No Pain with Walking
- Other: _____

Respiratory

- Yes No Cough
- Yes No COPD
- Yes No Wheezing
- Yes No Recurrent Respiratory Infections
- Yes No Shortness of Breath
- Other: _____

Psychological

- Yes No Depression
- Yes No Anxiety
- Other: _____

Endocrine

- Yes No Excessive Thirst/Fluid Intake
- Yes No Temperature Intolerance
- Yes No Feeling Tired (Fatigue)
- Yes No Hot Flashes
- Other: _____

Hematologic/Lymphatic

- Yes No Swollen Glands
- Yes No Blood Clotting Problem
- Yes No Easy Bruising
- Yes No Bleeding Tendencies
- Other: _____

Neurological

- Yes No Tremors
- Yes No Dizzy Spells
- Yes No Numbness/Tingling
- Yes No Headache
- Yes No Unsteady Gait
- Yes No Feeling Weak
- Yes No Convulsions/Seizures
- Other: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____