PHYSICIANS' CLINIC
of Iowa, P.C.

HEMATOLOGY & ONCOLOGY QUESTIONNAIRE

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

FEMALE PATIENTS ONLY

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

Eyes
☐ Yes ☐ No Blurry Vision
☐ Yes ☐ No Double Vision
☐ Yes ☐ No Wear Glasses
☐ Other: _____

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

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

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: _____

Psychological
☐ Yes ☐ No Depression
☐ Yes ☐ No Anxiety
☐ 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: _____

Skin
☐ Yes ☐ No Skin Rash
☐ Yes ☐ No Itching
☐ Yes ☐ No Discoloration
☐ Yes ☐ No Lumps or Masses
☐ 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: _____

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: _____

This form is destroyed after the information is entered and verified in the patient's electronic health record.