PLACE LABEL HERE

HEMATOLOGY/ONCOLOGY NEW PATIENT QUESTIONNAIRE:

Sex: _____ Person completing this form: _____
Why are you here to see the doctor? _____

_____

Does the child have any allergies (including environmental, medication, food, reaction to previous blood transfusion)? ○YES ○NO
If YES - Please list: _____

_____

Is the child currently taking any medications or drugs (including over-the-counter, prescription, health store medications, birth control pills)?
○YES ○NO If YES - Please list: _____

_____

Does the child have any chronic conditions or any previous serious illnesses? ○YES ○NO If YES - Please list: _____

_____

SURGICAL/HOSPITALIZATION HISTORY: ○NO ○YES

Date	Surgery Performed and/or Reason for Hospitalization	General Anesthesia or Sedation Given?	List any problems with General Anesthesia
		○YES ○NO	
		○YES ○NO	
		○YES ○NO	

PATIENT SUBSTANCE USE:

Tobacco: ○Never ○Quit ○Passive ○YES / Alcohol: ○NO ○YES _____oz/wk / Drugs: ○NO ○YES _____use/wk

BIRTH HISTORY:

○Full Term ○Premature (Weeks ____) ○Vaginal ○Caesarean ○Healthy at Birth Birth Length: _____ Birth Weight: _____
If Hospitalized, Where? _____ Birth/Pregnancy Problems (if any): _____

_____

Please continue to next page >

Please return completed form to the medical assistant or nurse.

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HEMATOLOGY/ONCOLOGY NEW PATIENT QUESTIONNAIRE:

Patient's Name: _____

FAMILY HISTORY: Please indicate the child's family history. For Aunt, Uncle and Grandparents note **M** for Maternal and **P** for Paternal

	None	Mother	Father	Brother	Sister	Aunt	Uncle	Grandmother	Grandfather
DVT/pulmonary embolism									
Kidney Disease									
Heart Disease									
Asthma									
Stroke									
Congenital Hearing Loss									
Anemia									
Bleeding Problems									
Sickle Cell Anemia									
Diabetes									
Cancer									
Anesthesia Problems									
Hypertension									
OTHER									

SOCIAL HISTORY:

Are there any smokers in the patient's home? ○YES ○NO If YES - Who? _____
Child lives with (check applicable) ○Mom ○Dad ○Grandparent ○Brother (#): ___ ○Sister (#): ___ ○Foster Parent
○Legal Guardianship/Custody: _____
Mother's Age: _____ Mother's level of education: ○High school diploma/GED ○Some College ○College Graduate
Father's Age: _____ Father's level of education: ○High school diploma/GED ○Some College ○College Graduate
List all sibling(s) Name: _____ Age: _____ Same Parents ○YES ○NO /
Name: _____ Age: _____ Same Parents ○YES ○NO
Name: _____ Age: _____ Same Parents ○YES ○NO
Name: _____ Age: _____ Same Parents ○YES ○NO
Name: _____ Age: _____ Same Parents ○YES ○NO
Name: _____ Age: _____ Same Parents ○YES ○NO
Pets: _____ ○Other: _____
Is the patient enrolled in CMS? ○YES ○NO Other Agencies involved with this patient? ○YES ○NO Agency Name: _____
Do you have transportation needs? ○YES ○NO If YES - Please explain: _____

Please continue to next page >

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HEMATOLOGY/ONCOLOGY NEW PATIENT QUESTIONNAIRE:

Patient's Name: _____

REVIEW OF SYSTEMS: Please indicate wether the following are problems for your child. (CHECK ALL THAT MAY APPLY)

NEWBORN:
- ○ Healthy at Birth
- ○ Apnea
- ○ Retinopathy
- ○ Bradycardia
- ○ Intraventricular Hemorrhage/Head Bleed
- ○ Incubation/Mechanical Ventilation
- ○ BPD (Bromchopulmonary Dysplasia)
- ○ Other/Details:

_____

CONSTITUTIONAL/GENERAL:
- ○ Normal
- ○ Frequent Infection
- ○ Fever
- ○ Weight Loss
- ○ Fatigue
- ○ Unusual Sweating
- ○ Other/Details:

_____

EYES:
- ○ Normal
- ○ Double Vision
- ○ Glasses
- ○ Blurry Vision
- ○ Swelling of Eyes
- ○ Other/Details:

_____

EARS/NOSE/THROAT:
- ○ Normal
- ○ Hearing Problems
- ○ Chronic Ear Infections
- ○ Bleeding Gums
- ○ Difficulty Swallowing
- ○ Nosebleeds
- ○ Snoring
- ○ Mouth Sores
- ○ Loose Teeth
- ○ Frequent Upper Respiratory Infection/Cold
- ○ Other/Details:

_____

RESPIRATORY:
- ○ Normal
- ○ Asthma
- ○ Shortness of Breath
- ○ Chest Pain
- ○ TB
- ○ Aspiration
- ○ Croup
- ○ Pneumonia
- ○ Chronic Cough
- ○ Tracheostomy/Intubation/Mechanical
- ○ Other/Details:

_____

CARDIAC:
- ○ Normal
- ○ Congenital Heart Defects
- ○ Racing Heart
- ○ Cardiotoxic Drugs
- ○ Blood Pressure Problems
- ○ Murmurs
- ○ Arrhythmias (Irregular Heartbeat)
- ○ Other/Details:

_____

GENITOURINARY:
- ○ Normal
- ○ Kidney Disease
- ○ UTI (Urinary Tract Infection)
- ○ Vesicoureteral Reflux
- ○ Vaginal Bleeding
- ○ Excessive Urination
- ○ Stones
- ○ Ovary Problems
- ○ Undescended Testicle
- ○ Excessive Menstruation
- ○ Incontinence
- ○ Pelvic Pain
- ○ Blood in Urine
- ○ Testicular Mass/Pain
- ○ Other/Details:

_____

HEPATIC:
- ○ Normal
- ○ Liver Disease
- ○ Jaundice (Yellow Skin)
- ○ Gall Stones
- ○ Hepatitis
- ○ Pancreatitis
- ○ Other/Details:

_____

NEUROLOGIC:
- ○ Normal
- ○ Seizures
- ○ Migraines
- ○ Stroke
- ○ Change in School Performance
- ○ Weakness
- ○ Dizziness
- ○ Headache
- ○ Walking Problems
- ○ Hydrocephalus/Shunt
- ○ Meningitis
- ○ Balance Problems
- ○ Other/Details:

_____

GASTROINTESTINAL:
- ○ Normal
- ○ Diarrhea
- ○ Vomiting/Nausea
- ○ Abdominal Pain/Swelling
- ○ Constipation
- ○ GE Reflux
- ○ Blood in Stool
- ○ Hepatitis
- ○ Colitis
- ○ Vomiting Blood
- ○ Other/Details:

_____

(Review of Systems continued on next page)

Please continue to next page >

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HEMATOLOGY/ONCOLOGY NEW PATIENT QUESTIONNAIRE:

Patient's Name: _____

REVIEW OF SYSTEMS: Please indicate wether the following are problems for your child. (CHECK ALL THAT MAY APPLY)

MUSCULOSKELETAL:
- ○ Normal
- ○ Muscle Disease
- ○ Arthritis
- ○ Muscular Dystrophy
- ○ Scoliosis
- ○ Fractures
- ○ Neck Pain
- ○ Back Pain
- ○ Joint Pain
- ○ Bone Pain/Mass
- ○ Other/Details:

_____

HEMATOLOGIC:
- ○ Normal
- ○ Bleeding Disorder
- ○ Prior Transfusion
- ○ Pallor
- ○ Anemia
- ○ Leukemia
- ○ Blood Clot
- ○ Easy Bleeding/Bruising
- ○ Lymphoma
- ○ Other/Details:

_____

SKIN:
- ○ Normal
- ○ Rash
- ○ Eczema
- ○ Easy Bruising
- ○ Birthmarks
- ○ Scars
- ○ Pallor
- ○ Hemangioma
- ○ Burns
- ○ Other/Details:

_____

ENDOCRINE/METABOLIC:
- ○ Normal
- ○ Diabetes
- ○ Thyroid Disorders
- ○ Inborn Errors of Metabolism
- ○ Adrenal Disorders
- ○ Other/Details:

_____

PSYCHOSOCIAL:
- ○ Normal
- ○ Developmental Delay
- ○ Learning Disability
- ○ Substance Abuse
- ○ ADD/ADHD
- ○ Autism
- ○ Depression
- ○ Other/Details:

_____

DEVELOPMENTAL HISTORY: Answer all questions that apply to your child's age.

Is your child toilet trained? ○YES ○NO If YES Do you have concerns regarding toilet training? _____

For **Infants/Toddlers**:

Does your child: Roll over? ○YES ○NO Sit alone? ○YES ○NO Walk? ○YES ○NO Talk? ○YES ○NO Drink from a cup? ○YES ○NO

For **Preschool** Children:

Attend daycare? ○YES ○NO Has there been concern over development or speech? ○YES ○NO

For **School Age** Children:

Grade: _____ School: _____ School Performance: _____

Other activities (work, sports, church, etc): _____

Has your child's intelligence or development ever been tested? ○YES ○NO If YES, by Whom, Where, & When? _____

_____

Up to date on Immunizations? ○YES ○NO Which: _____

For girls: Age first menstruated? _____

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